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LIFE AFTER STROKE: AN ETHNOMETHODOLOGICAL STUDY OF EMOTION WORK AMONG ADULT STROKE SURVIVORS AND THEIR CARERS IN RURAL AREAS OF NAKHON SAWAN PROVINCE, THAILAND

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Abstract

This thesis aims to explore the nature of emotion work within the context of care occurring in adult stroke survivors (18-59) and their carers situated at home in Nakhon Sawan Province, Thailand. It also investigates how their roles were constructed after the stroke event. An ethnomethodological approach facilitated the understanding of the sense-making processes in daily routines. Data collection was comprised of semi-structured interviews and observations which were gathered from a sample of twelve pairs of stroke survivors and carers, 24 participants in all, over a period of three months. Data were analysed by a thematic analysis approach.

Stroke survivors' belief about the cause of stroke and its effects on their attitude towards themselves and carers, and carers' accounting for their care of stroke survivors emerged as two overarching themes derived from the interview data. The first theme illustrates that stroke survivors described difficult experiences during the first six months post stroke as the turning point of their lives. They searched their life experiences to create their current status within society. A self-evaluation of their health created a positive or negative attitude towards themselves, which affected their emotions in everyday living. In all cases the stroke survivors' appreciation of carers' help was significant. For carers, family relationships and expectations influenced their sense of responsibility and expectations. The feeling of gratitude, the morality of Buddhist values and a sense of duty were their underlying reasons for taking the caring role. Carers' expectations of stroke survivors' ability to perform routine activities were influential in managing their own feelings and actions in everyday life. The influence of neighbours reinforced carers' ideas of moral standards of caring for stroke survivors.

Emotion management is the third theme. Emotion work is involved in stroke survivors' and carers' everyday affairs which helped to keep their current life situations in balance and assist them in continuing to live as normal. Their life experiences and specific feeling rules (the feeling of gratitude and the sense of responsibility) govern the achievement of their emotion work. A differentiation between male and female roles also influenced their emotion work.

Stroke survivors and carers presented how emotion work served to maintain their interpersonal relationship and to minimise difficult conditions in ordinary living. A conceptual framework of the process of emotion work is presented to facilitate understanding of how they engage in and accomplish emotion work during caring interactions. Emotion work emerges as a means to show their gratitude to each other and represents one of several ways to fulfil their Buddhist beliefs in the law of karma. They exchange emotion work for the values of caring and gratitude.

These findings will be beneficial to stroke survivors and carers for dealing effectively with emotional problems in day-to-day life. Community nurses and other health professionals will gain a deeper knowledge of emotion work in order to assist them in providing holistic care for stroke survivors and carers. The findings will also be of interest to health policy makers to enable them to organise information and home-healthcare activities in future stroke care and health promotion strategies in rural communities in Thailand and elsewhere.

Declaration

This is to certify that the work contained herein has been composed by me and is entirely my own work. No part of this thesis has been submitted for any other degree or professional qualification.

Maturada Muangman

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Chapter 1
Introduction

1.1 Introduction

This thesis presents a qualitative enquiry into adult stroke survivors' and carers' emotion work during caring interactions and their experience of undertaking emotion work in everyday lives. An ethnomethodological approach has been adopted for this study.

This study was initiated through the intention of contributing towards an optimum pattern of care and rehabilitation of stroke survivors in the family home. I have had an enduring interest in stroke survivors' and carers' ways of life after discharge from hospital because the long-term disablement following stroke can create large burdens for both stroke survivors and carers. Over a number of years whilst working as a registered nurse in a community hospital in Nakhon Sawan, Thailand, I observed at first hand stroke survivors and their carers making every effort in overcoming their life's difficulties, including emotional issues. Over two years I undertook the role of an informal carer for an elderly stroke survivor in the home, where I experienced emotional distress and learnt to cope with the emotional problems and how to manage my emotions and feelings in a given situation. These experiences led me to believe that emotional factors might be of underlying significance in enhancing the well-being of stroke survivors and carers.

1.2 Importance of the study

Much attention has been given to stroke as a result of being the second major cause of death in Thailand. In 1997, the stroke mortality rate in Thailand was 10.1 deaths per 100,000 population; by 2007 this rose to 20.6 deaths per 100,000 population, an increase of approximately 100 percent within a period of ten years (Non-Communicable Disease Information Centre 2007). Stroke is also the leading cause of long-term disability. Most stroke survivors are able to live at home, but assistance

from informal carers may be required to help them perform everyday activities (Brass 2006; Stroke Association 2012a). The nature of the stroke trajectory and its frequently damaging effects which might affect survivors' and carers' quality of life are demonstrative of the need for further stroke research into post-discharge care management.

Because of lack of inpatient rehabilitation facilities, not all stroke patients are referred to medical rehabilitation services after the acute stage (Dajpratham et al. 2009), although there is a gradual increase in rehabilitation services for neurological patients in Thailand (Kuptniratsaikul et al. 2009). Kuptniratsaikul et al. (2008) found that over 80 percent of stroke survivors were discharged from hospital to their own home for ongoing recovery. They receive significant support, i.e. physical, social and rehabilitation activities from informal carers such as spouses, parents, relatives and friends in the home environment (Baumann et al. 2012; Jullamate et al. 2006). It appears that most stroke survivors continue lives suffering from functional impairment and disability, and informal carers become the key person in stroke recovery at home. Stroke survivors and carers might be faced with an overwhelming sense of burden from this life-changing experience and its adverse impact.

A number of studies worldwide have highlighted the extent to which stroke events can make physical, psychological, economic and social impacts on stroke survivors and carers (Draper and Brocklehurst 2007; Green and King 2009; Greenwood and Mackenzie 2010; Hoffmann et al. 2003; Larson et al. 2005; McCullagh et al. 2005; Paul et al. 2005). Although the majority of studies on stroke outcomes have focused on adverse consequences of physical health and functioning, stroke survivors and carers are prone to significant experiences of emotional burdens, e.g. depression, anxiety, fear and stress (Nidhinandana et al. 2010; Oupra et al. 2010). These emotional problems can affect stroke survivors' and carers' quality of life and well-being (Chow et al. 2007; Greenwood et al. 2008; Klinedinst et al. 2009; Sturm et al. 2004; Visser-Meily et al. 2009).

The state of individual emotions and interpersonal relationships between stroke survivors and carers may contribute to stroke recovery and enhancing their quality of life (Jaracz and Kozubski 2003; Paul et al. 2005). Bluvol and Ford-Gilboe (2004) stated that stroke survivors' hopes for further improvement and the quality of family health influenced their quality of life. The outcome of stroke recovery in physical, cognitive and psychosocial functions was closely linked to family support and carers' emotions (Lutz and Young 2010). Franzén-Dahlin et al. (2007) found that stroke carers with less robust psychological health could negatively influence the rehabilitation process of stroke survivors. This indicates that the issue around stroke survivors' and carers' emotions is inextricably linked to their well-being. Within this context of adaptation to life, stroke survivors and carers must try to sort out how to keep their emotions and feelings in balance in order to go on living. These insights led me to focus on the emotional component of stroke survivors' and carers' lives following stroke in order to afford new insight into emotional regulation at home.

The term 'emotional labour' which was first used by Hochschild (1979, 1983) is compatible with my aims of understanding and gaining new theoretical ideas about the management of emotions during caring interactions between stroke survivors and carers in a stable home environment in rural Thailand. The definition of 'emotional labour' is the management or suppression of one's feelings "in order to sustain the outward countenance that produces the proper state of mind in others" (Hochschild 1983: 7). 'Emotion work' (or 'emotion management') and 'emotional labour' are similar. Emotion work is used when individuals regulate their own emotions and feelings for producing acceptable displays in the private context. The other is used in the workplace as part of paid labour (Hochschild 1983, Smith 2012).

I use the term 'emotion work' because my study focuses on the emotional management process which takes place in the home environment. The process of individual emotion work is guided by feeling rules based on ideology, cultural standards, individual beliefs and reactions from others. Feeling rules shape individuals' feelings and outer actions in given situations (Hochschild 1983; James 1989; Smith 2012). The emotional states which individuals publicly express might be

different from their authentic feelings. In this situation, creating a superficial emotion might lead them to experience psychological strain and emotional exhaustion (Chang and Chiu 2009; Rantanen et al. 2011). Therefore, emotion work in the aftermath of a stroke event and experiences of caring interactions between stroke survivors and carers might influence their quality of life and emotional well-being.

There is a paucity of research in the field of emotion work regarding interpersonal relationships between stroke survivors and carers. Little is known about stroke survivors' and carers' management of emotions following stroke and its impact on their quality of life and well-being in Thailand. In the home environment, achieving emotion work might be an important factor for improving interpersonal interactions and communication between stroke survivors and carers. I wondered in what way the expression of emotions following the stroke relates to feeling rules and prior knowledge of stroke survivors and carers. Therefore, this study aims to explore stroke survivors' and carers' experiences of emotion work during caring interactions, to understand how they create their own roles and how they construct their ideas of engaging in emotion work, and to investigate how they cope with challenges to their everyday lives in a given situation and the impact of the altered relationship between them.

This study focuses on adult stroke survivors (18-59 years old) and carers. Stroke in this age group hinders their quality of life, social life and work abilities (Putaala et al. 2009). There is enormous potential for long-term impairment leading to a lifetime of disability for stroke survivors and heavy burdens for carers and families. Although stroke is a relatively common event at ages of over 60 years (Sridharan et al. 2009), incidence rates of stroke in adults below 60 are not rare worldwide (Lipska et al. 2007; Marini et al. 2011; Venketasubramanian et al. 2005). In Nakhon Sawan Province, Thailand, many stroke patients are admitted to Sawanpracharak hospital, which is a tertiary-care hospital in Nakhon Sawan Province. Of 1,115 stroke cases recorded in the year 2006, 204 cases were under the age of 60. The admission rates of adults with stroke increased from 275 in 2007 to 312 in 2008 (Sawanpracharak

2009). Most stroke survivors who returned home with a decrease in physical functioning were looked after by their family carers.

The main criterion for selection of place is rural areas of Nakhon Sawan province. I decided to study in this setting for three reasons. Firstly, I am interested in family structure, family lives and the quality of family relationships in rural communities where main carers of stroke survivors might be provided with additional support from other family members, relatives, friends and neighbours. Secondly, the study site corresponds with the focus of the Tenth National Economic and Social Development Plan (2007-2011) of Thailand. The policy has scoped out and focused on nursing interventions towards health promotion and disease prevention, especially chronic illness, and relying on oneself for well-being. Rural areas are a main target for applying this policy (National Economic and Social Development 2007). Thirdly, I am familiar with working with people with chronic illnesses including stroke survivors and carers in rural communities in Nakhon Sawan province, and I have been witness to those family and community care networks.

In summary, I intend to study this topic because of the following gaps and stroke problems in Thailand: the number of adult strokes is rising (Non-Communicable Disease Information Centre 2007; Sawanpracharak 2009); following the stroke event many patients have a long-term disability and may lose both working and social life although of traditional working age; the prevalence of depression is a serious concern after physical impairment problems in Thailand (Nidhinandana et al. 2010); there is a paucity of Thai research in strokes and disabilities in relation to medical and social models and social participation; there is a lack of research into the area of emotion work in the community; and it corresponds to health polices in Thailand (National Economic and Social Development 2007).

1.3 Thesis structure

The structure of the thesis is shown in Figure 1.1. This gives a brief outline of the ten chapters and demonstrates how they are organised.

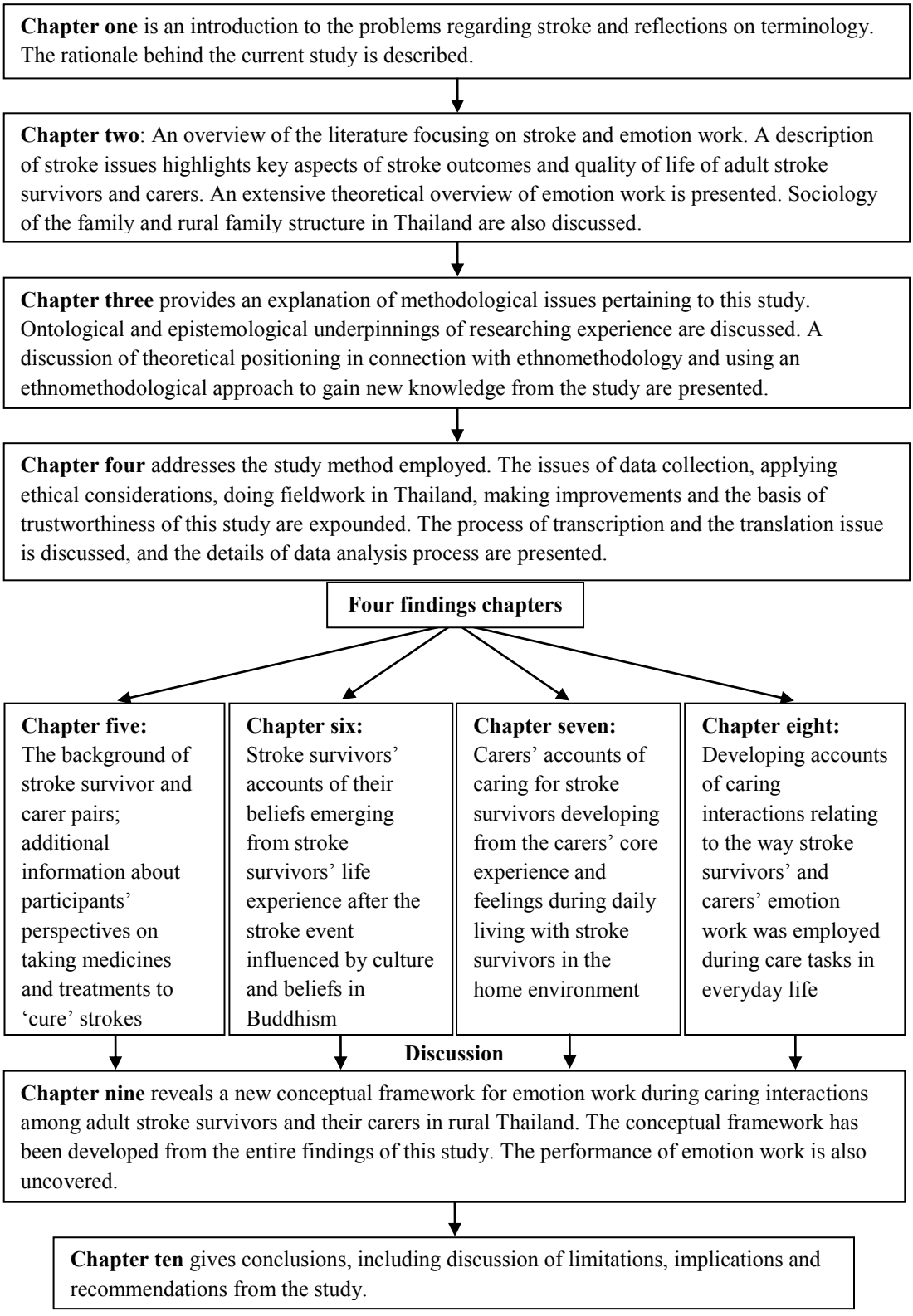


Figure 1.1: Schematic outline of the thesis

The next chapter discusses the literature on stroke, emotion work and sociology of the family.

Chapter 2

Literature Review

2.1 Introduction

This chapter reviews the literature concerning adult stroke survivors' and carers' experiences of emotion work occurring in the home environment. The body of literature focuses on three key aspects as they are relevant to my research questions. The first aspect is to examine stroke survivors and carers following a stroke event from various perspectives. Stroke literature is focused on discussions about stroke in adults regarding risk factors for stroke, effects of stroke and impact on stroke survivors' and carers' psychological issues and their quality of life. Definition of stroke ability is presented. In the second aspect, Hochschild's concept of emotion work (1979, 1983) is discussed. A number of previous research studies of emotion work in the field of work and family are examined. Finally, the context of Thai families and family structure based on Thai culture are explicated.

Search methods

The following electronic search engines were accessed for relevant studies: CINAHL (Cumulative Index to Nursing and Allied Health Literature), Medline (Medical Literature Analysis and Retrieval System Online), Science Direct, and the library catalogue for English journals. The search was not an attempt to conduct a systematic review. The key words for searching included stroke, stroke in adult age, stroke survivors, carers, effect of stroke, outcome, impact, psychological perspective, recovery, disability, rehabilitation, well-being, quality of life, home environment, emotion, feeling, emotion work, emotional labour, feeling rules, family, Thai culture and Thai family in various combinations. Thai language literature was also consulted. Additional searches were also identified through the reference lists of relevant studies.

2.2 Stroke

The World Health Organization (WHO) definition of 'stroke' or 'cerebrovascular accident' (CVA) is "a clinical syndrome of rapidly developed clinical signs of focal or global disturbance of cerebral function, lasting more than twenty-four hours or leading to death with no apparent cause other than vascular origin" (Scottish Intercollegiate Guideline Network 2004: 1). The definition involves subarachnoid haemorrhage. The obstruction of blood flow caused by infection or tumour and transient ischaemic attack (TIA) in which the appearance of stroke symptoms lasts less than twenty-four hours are excluded from this definition (Baker 2008; Ebrahim and Harwood 1999).

Stroke is a sudden brain attack resulting from the cerebral blood flow being disrupted. It is classified into two broad types, ischaemic stroke and haemorrhagic stroke. Approximately 80 percent of stroke patients have ischaemic stroke caused by the blood vessels that supply the blood to the brain getting blocked. Causes of ischaemic stroke are a thrombosis (a blood clot) which forms slowly inside a blood vessel, and atherosclerosis formed of blood fat, cholesterol and calcium, which induces an artery stenosis or a narrowing of the inner surface of the blood vessel. An embolus is similar to a thrombosis, but it develops and moves from somewhere else in the body and eventually obstructs the brain artery. The lack of oxygen and vital nutrients which are conveyed in the blood circulation results in damage to brain cells in the area. Around 10-20 percent of stroke is caused by cerebral haemorrhage or ruptured aneurysm caused by an artery exploding and the bleeding of a blood vessel supplying the brain. A leakage of blood into the brain causes damage (Mant 2011; NHS Quality Improvement Scotland 2005; Stroke Association 2012a).

Globally, each year around fifteen million people experience a stroke. One-third (5 million people) of all stroke patients die, and another one-third have a permanent disability (World Health Organization 2002a). The mortality rate within one month after the onset of stroke is up to 80 percent of all stroke patients and approximately 30-40 percent survive after one year (Mant 2011). In the United States, for example,

the duration of hospitalisation for stroke averages 5.3 days. As observed at six months after stroke onset, 50 percent of stroke survivors had weakness on one side of the body. Twenty-six percent and 30 percent of the survivors needed the support of some assistance in order to walk and to perform their daily routine respectively (Roger et al. 2012).

2.2.1 Defining adult age group

When attention is drawn to adult people who experience stroke, the definition of adult age group requires clarification. It is elusive to define the adult age range due to no general agreement on the age of transition from childhood to adulthood and at which a person becomes old. There are many concepts to categorise each age group focusing on a specific adulthood period. For example, United Nations (2004) age categories are: children (0-14 years), youth (15-24 years) and adults (25-59 years), while older persons are the age of 60 years and over. World Health Organization (2012) uses ages between 15-60 years old to define the term 'adult mortality rate'. In psychiatry, scholars distinguish between studies of children and adults by age range. The former have an age range of 5-17 years, while adult studies refer to 18-60 years of age (Emslie 2012).

As shown in Table 2.1 below, recent studies on stroke published in literature worldwide set different limits for an adult age group. Overall the adult age range encompasses 15 to 60 years old. The lower age limit varies from 15 to 35 years of age, with the majority of the lower age limits being 18 years. The upper age limit is between 44 and 60 years old with the age of 45 frequently used to limit upper age for adult stroke. However, many studies specify an age group for stroke in young adults, commonly keeping it between $\geq$15 and $\leq$ 45 years of age. This may be because the research impetus is towards the set of causes and effects of stroke in younger age groups, which may differ from older age groups (Prasad and Singhal 2010). If the age of 45 is accepted as the upper limit of the adult age group and over 60 years old refers to elderly people, this will leave a huge gap in people in the age group 45-60 years. It looks like the trend is to have 15-45 as young adult, then presumably 45-60 is adult.

Table 2.1 Studies with regard to stroke presenting in adult age groups from outside Thailand

Author(s)	Country	Age group (yrs)	Sample size	Aim of the study
Lipska et al. (2007)	India	15-45	214	Risk factors
Bandaru et al. (2009)	India	< 45	240	Etiology study
Putaala et al. (2009)	Finland	15-49	1,008	Occurrence, risk factors, etiology and neuroimaging features
Baptista et al. (2010)	Portugal	18-55	493	Relationship between GLA mutations and prevalence of stroke
Bi et al. (2010)	China	35-45	1,988	Risk factors and treatment status
Sheu et al. (2010b)	Taiwan	18-50	2,340	Risk factors
Spengos and Vemmos (2010)	Greece	15-45	253	Risk factors, etiology and outcome
Tan et al. (2010)	Malaysia Australia	18-49	128	Risk factors and etiology
Zhang et al. (2010)	China	18-45	585	Relationship between serum uric acid and clinical prognosis
Greisenegger et al. (2011)	Austria	18-60	661	Clinical predictors of death
Rolfs et al. (2011)	15 European countries	18-55	5,024	Multicenter epidemiological study
Rutten-Jacobs et al. (2011)	The Netherlands	18-50	1,006	Risk factors and prognosis
Siegerink et al. (2011)	The Netherlands	18-50	175	Etiology study
Groppo et al. (2012)	Italy	15-44	39	Incidence and prognosis
Hsieh et al. (2012)	Taiwan	≤ 50	305	Epistasis analysis

Table 2.2 Studies with regard to stroke presenting in adult age groups in Thailand

Author(s)	Location	Age group (yrs)	Sample size	Aim of the study
Dharmasaroja (2008)	Thammasat university hospital	≤ 45 >45	25 169	Baseline characteristics of the patients
Manimmanakorn et al. (2008)	9 hospitals across Thailand	18-44, 45-64, > 65	327	Rehabilitation Outcome
Masskulpan et al. (2008)	9 rehabilitation centres	> 18	251	The occurrence of anxiety and depressive symptoms
Kovindha et al. (2009)	9 tertiary hospitals, 6 university hospitals	> 18	185	prevalence of incontinence
Kuptniratsaikul et al. (2009)	9 tertiary hospitals, 6 university hospitals	≥ 18	327	Outcomes of stroke rehabilitation
Bandasak et al. (2011)	A private Hospital	18-45	98	Risk factors
Dharmasaroja et al. (2011)	Thammasat university hospital	16-50	99	Causes of ischemic stroke
Ratanakorn et al. (2012)	Ramathibodi hospital	≥ 18	464	Impact of Stroke Fast Track (SFT)
Singhpoo et al. (2012)	Srinagarind Hospital	> 20	237	Factors related to Quality of Life

Table 2.2 illustrates recent research studies on stroke in adult age groups which were carried out in Thailand. The studies are aimed at adult people in the 16-65^{+} age range. The age from 16 to 20 is displayed as the lower age limit of these studies. The majority limit the lower age to 18 years old. Of all studies, only three studies specify an upper age limit, the highest one being 64 years of age. It is noticeable that the main focus of studies in relation to adult stroke issues seems to be an interest in aspects of the whole range of adulthood. However, these studies are also associated with a variety of places, sample sizes and study aims.

According to the overall focus on the limits of age in Table 2.1 and 2.2, the majority of the studies take the lower age limit as being 18 years of age. The upper age limit varies from 44 to 65 years. For my study, the general definition of adult age is

between 18 and 59 years old (< 60 years old). The rationale for choosing the lower limit as the age of 18 is because most studies on adult stroke in Thailand and worldwide begin at this age. A person at the age of 18 usually graduates from high school and enters working age, although the age that young people become adults varies widely in all cultures (Arnet 2004; Sorensen 2008). The chronological age of 18-25 is also a definition of emerging adulthood (Arnet 2009). The age of 59 I have chosen for defining the upper age limit is because of the intention to cover the gap between young adult and elders (45-60 years old) as noted earlier in this section. In Thailand, the elderly population is defined as 60 years of age and older nowadays. Moreover, 60 is the official retirement age and the lowest age to apply for the Old Age Pension Fund under Social Security (National Economic and Social Development Board (NESDB) and United Nations Population Fund (UNFPA) 2011).

Most studies above do not give their rationale for an age-specific adult group in the reports. I decided to use 18-59 years of age as the definition of an adult person for my study. The definition of the adult age group rests upon four main issues. Firstly, the focus of this study is on working-age adults. The second issue is overall alignment with the population-based studies' definitions of the age category for stroke in adult age as discussed above. The third issue is consideration of a change of social role in adulthood such as work patterns, family role, sexual relationship, leisure and friendships (Arnet 2009; Mant 2011; Sorensen 2008). The final issue is in the area of long-term care and continuing rehabilitation addressing the needs of the adult stroke population. The last two issues are concerned with the impact of stroke in adult age in association with stroke survivors' and carers' emotions in everyday lives.

2.2.2 Stroke in adult age

Although the incidence of stroke occurs significantly in older people, every year many younger adult people suffer a stroke (Stroke Association 2012b). The findings of previous studies showed the difference in adult stroke incidence worldwide (Groppo et al. 2012; Prasad and Singhal 2010; World Health Organization 2002a).

For example, the European Registers of Stroke (EROS) Investigators (2009) which was conducted between 2004 and 2006 and utilised data on stroke incidence in 6 European countries, 29.8 percent of all strokes occurred in patients under 65 years of age. Putaala et al. (2009) studied a trend in the occurrence of patients in Helsinki aged 15 to 49 with their first-ever ischaemic stroke and reported that the average annual occurrence rate was 10.8 per 100,000. Sridharan et al. (2009) studied the incidence of first-ever stroke in India and found that 3.8 percent of all stroke patients were under age 40. Ong and Raymond (2002) demonstrated that around 30 percent of all stroke patients admitted to Penang Hospital, Malaysia were between 35 and 60 years of age. Marini et al. (2011) reviewed 29 articles published after 1980, with particular attention to the incidence rate of first-ever stroke in people under 45 years old. There was evidence to suggest that it is not so rare to find a stroke in this age group and that specific programmes of stroke prevention are required.

In Thailand, stroke morbidity rate per 100,000 was reported at around 496,800 patients of Thai population (Thai Health Promotion Foundation, 2008). The death rate caused by hypertension and cerebrovascular diseases in 2009 was 129.56 per 100,000 population (Statistical Forecasting Bureau 2011). Dharmasaroja et al. (2011) found that 20 percent of all ischaemic stroke patients were in people aged 16-50 years old of which 13 percent occurred in those under 45 years. Ischaemic stroke was found in 71.9 percent of all stroke patients admitted to nine main tertiary hospitals (Kuptniratsaikul et al. 2008). It is becoming more important to focus on research into stroke in Thai adult people under age 60.

Risk factors for stroke

Risk factors for stroke in younger adults are much the same as in older people. The factors include smoking, hypertension, diabetes mellitus, heart problems, sickle cell disease, ethnic background, heavy alcohol drinking, taking recreational drugs and combined oral contraceptive pills (Stroke Association 2012a, 2012b). There is a large volume of published studies examining the risk of stroke. For example, Rist et al. (2010) reported that people who consumed one alcohol drink per week had the lowest risks of stroke incidence. Around 18-20 percent of ischaemic strokes are

associated with obesity measures defined by body mass index ≥28.1kg/m^2, waist circumference ≥100 cm. or waist-to-hip ratio ≥0.95 (Yatsuya et al. 2010). Soyama et al. (2003) studied the incidence of stroke in a rural area of Japan and found that decreasing stroke rates were connected to higher levels of High-Density Lipoprotein Cholesterol (HDL-C). Rexrode (2010) reported that a relationship between the use of exogenous oestrogen and increased stroke risk was seen in women.

Data from several sources have identified other factors associated with the increased risk of stroke such as reflux oesophagitis (Sheu et al. 2010b), migraine (McDade and Kittner 2009), tuberculosis (Sheu et al. 2010a), hypertriglyceridemia (Towfighi et al. 2010), arsenic which is carried in groundwater, drinking water, inhaled air and food (Lisabeth et al. 2010; Saposnik 2010), and the mutation of Gal gene locus (GLA) (Baptista et al. 2010). As explained above, these studies have revealed stroke issues and its associated risk factors approached in various community-based studies worldwide. In Thailand, hypertension, smoking and diabetes mellitus are the traditional major risk factors (Arayawichanont 2010; Kuptniratsaikul et al. 2008; Ueshima et al. 2008). Consequently, stroke in younger adults will continue to be of concern regarding its risk factors in order to identify individuals at high risk and prevent stroke. The risk of stroke appears to be associated with unhealthy lifestyles.

Effects of stroke

A group of signs and symptoms of impaired neurological conditions result from having a stroke (Arayawichanont 2010; Gokkaya et al. 2005; King et al. 2001). Every stroke produces various symptoms and effects on stroke patients depending on the location and severity of brain damage. The effects of stroke on younger adults are the same as on older people. However, by comparison with older people, stroke in younger adults might be less complicated by underlying illnesses (Stroke Association 2012b). A large volume of both quantitative and qualitative research approaches are used for investigating effects of stroke on stroke survivors. The common effects of stroke for stroke survivors can be divided into three types of problems: physical, psychological and social problems.

Physical problems are recognised as the most common problem following stroke resulting from loss of brain function due to neurological damage. The problems include paralysis, loss of balance, pain, tiredness resulting from sleep-wake disturbances, visual problems, urinary incontinence, speech and communication problems (aphasia and/or dysarthria) and swallowing difficulties (Caplan and van Gijn 2012; Scottish Intercollegiate Guideline Network 2002). To give some examples, paralysis or weakness in one side of the body causes difficulties moving an arm and/or leg and performing routine activities for stroke survivors. Walker (2011) stated that around 80 percent of stroke survivors' walking ability will resume in the first year after stroke. Knoflach et al. (2012) found that age is a key factor in predicting good function after ischaemic stroke. Stroke survivors between the ages of 18 and 35 achieve the highest score on the mRS[1] instrument in three-month good functional outcome. There is a gradual decline in the outcome by 3.1-4.2 percent for each ten-year period, and a steep drop is shown after the age of 75. Perry and McLaren (2003) found that up to 61 percent of stroke survivors at 6 months after stroke have difficulty in swallowing or dysphagia. Deficits in eyesight (26 percent) and communication (27 percent) occur in stroke survivors.

Regarding psychological problems, the prevalence of depression in the acute phase of stroke was around 40 percent and between 18 percent and 54 percent occurred in the chronic phase. Anxiety was found in between 3.5 percent and 24 percent of all stroke patients (Marshall 2012). Most studies which have looked at psychological burdens claim that stroke survivors suffer from depression (Carod-Artal et al. 2000; King et al. 2001) and anxiety (Teasell et al. 2000). The effect of a bodily impairment on psychological problems is a mixture of different symptoms (Dennis et al. 2000). For example, West et al. (2010) studied psychological symptom trajectory in 444 stroke survivors at 2-6, 9, 13 and 26 weeks after stroke, and found that psychological

[1] The modified Rankin Scale for stroke disability (mRS) is used for describing a grade of the disability of stroke patients. Grade 0 refers to no symptoms at all. Grade I refers to no significant disability and able to carry out all usual duties. Grade II refers to slight disability, unable to carry out some of previous activities but able to look after own affairs without assistance. Grade III refers to moderate disability, requiring some help but able to walk without assistance. Grade IV refers to moderately severe disability, unable to walk without assistance and unable to attend to own bodily needs without assistance. Grade V refers to severe disability, bedridden, incontinent and requiring constant nursing care and attention (Quinn et al. 2008: 46; see also Shinohara et al. 2006).

disorder occurs in stroke survivors, and this is associated with physical impairment at 52 weeks. In Thailand, recent evidence suggests that the prevalence of depression is a serious concern following physical disability (Nidhinandana et al. 2010).

Robinson et al. (2005) claimed that approximately 14.9 percent of stroke survivors are estimated as suffering from uncontrolled emotions called Pseudobulbar affect (PBA). PBA, also called pathological emotions, emotional lability, emotional incontinence, and emotionalism, is pathological laughing and crying that are unrelated to environmental stimuli and are not congruent with a patient's underlying feelings of happiness and sadness. A patient with PBA has a lessening of control of the expression of his/her emotions in the way that would be usual for that person. Emotional lability can make those people feel acutely embarrassed, frustrated and angry (Garnock-Jones 2011; Pioro 2011; Robinson et al. 2005; the State of Queensland (Queensland Health) 2011), and a scheme for the rehabilitation of stroke survivors may be compromised by PBA symptoms (Scottish Intercollegiate Guideline Network 2002). Strowd et al. (2010) found that rising depression symptoms and declining quality of life among patients with movement disorder can be affected by PBA. Regarding pharmacological interventions, some medicines are used to treat PBA such as Dextromethorphan/quinidine (Garnock-Jones 2011) and anti-depressants (Pioro 2011). However, there is a tendency for patients with PBA symptoms to improve over time (Scottish Intercollegiate Guideline Network 2002).

A stroke can cause personality changes leading to some behaviour which might be problematic and affect carers' emotional well-being (Bulley et al. 2010). A list of the most common ways that people have personality changes after stroke was reported, e.g. "becoming impatient and irritable, becoming withdrawn and introspective (focussed inwards), showing a loss of inhibitions, for example making inappropriate comments or swearing, becoming aggressive, either verbally or physically, showing a loss of interest in aspects of his/her life he/she once enjoyed, becoming impulsive - making sudden, sometimes rash decisions and showing more stress and anger" (Stroke Association 2012c: 5-6). The personality changes are a combination of stroke survivors' behaviour, thought patterns and feelings. These changes might go

unnoticed by stroke survivors themselves, but they might become more noticeable for their family members and friends (Stroke Association 2012c).

The third type is social problems. Having activity limitations following stroke and its relationship to social interaction is often reported. For example, Daniel et al. (2009) conducted a systematic review of the social consequences for adult stroke survivors. Seventy studies reported a wide range of returning to work after stroke (0-100 percent) in which the range in proportions always referred to a measure of stroke recovery, rehabilitation and social outcomes. Stroke survivors also experienced problems in family relationships (5-54 percent), negative impacts on sexual function (5-76 percent), financial difficulties (24-33 percent) and deterioration in social activities (15-79 percent). Teasell et al. (2000) studied social issues and found that 15 percent of young stroke survivors separated within 3 months after discharge, following conflict with spouse, children and others, reported as 38 percent, 22 percent and 16 percent respectively. Thompson and Ryan (2009) stated that many stroke survivors are reluctant to leave their home and have a fear of going out for social activities with their spouse. O'Connell et al. (2001) reported that the loss of social participation such as loss of meeting with friends and work colleagues, lack of social and leisure activities, and unemployment were expressed by stroke survivors.

Although, there have been several reviews of the adverse effects of suffering a stroke including the negative impacts on physical and psychological being and loss of social activities, few scholars have been able to draw on any research into the positive aspects. For example, Pound et al. (1999) studied positive actions resulting from post-stroke events by both stroke survivors and carers. Some positive aspects, which may show more advanced coping mechanisms, were observed, such as creating new ways to do something, doing something more slowly and having the opportunity to relearn skills.

On the part of informal carers, there is a growing literature on low levels of unpaid carers' quality of life (Larson et al. 2005; McCullagh et al. 2005; O'Connell et al. 2001). Several studies have found that informal carers of stroke patients often

experience psychological burdens such as depression, stress, strain, and anxiety, physical illness, isolation and reduced quality of life (Draper and Brocklehurst 2007; Franzén-Dahlin et al. 2007; Klinedinst et al. 2009; Larson et al. 2005; Lutz and Young 2010). For example, decreased psychological well-being of stroke patients' spouses is mainly shown during the acute phase of stroke (Forsberg-Wärleby et al. 2001). Chow et al. (2007) found that stroke carers tend to have more anxiety and symptoms of depression and to develop poorer physical health. Greenwood and Mackenzie (2010) studied a meta-ethnographic synthesis of qualitative research in informal caring and found that loss and change in relationship and uncertainty in their roles were highlighted. Carers become vulnerable persons owing to lack of control and feeling stigmatised (Green and King 2009). An increase in domestic and caring workload, the experience of stress, anxiety, depression and loneliness, a reduction in life participation and a change in life expectations were emphasised in carers' perspectives on their experiences of stroke (Bulley et al. 2010). The need for information and support from health professionals and social facilities were also reported (Cecil et al. 2010; Greenwood et al. 2011). It can be said that stroke carers are sufferers who experience difficulty in understanding and accepting many aspects of changed situations in their lives following stroke.

On the contrary, Parag et al. (2008) argued that there were some reports of improvement in relationships between carers and their stroke survivors. Similarly, some researchers found that abilities to cope with problems, by which carers can adjust and adapt their roles in order to manage their life (Greenwood and Mackenzie 2010), including support from family members, affected and increased family well-being (Charnsri 2008).

Studies on stroke in adults and carers

Stroke in adults and its related issues have remained of interest to people and scholars worldwide. A considerable amount of literature has been published on stroke among adults and their carers. These studies were concerned with a wide range of related issues (Baptista et al. 2010; Palmcrantz et al. 2011; Putaala et al. 2009; Rolfs et al. 2011; Rutten-Jacobs et al. 2011; Teasell et al. 2000; Young et al.

2012). The aim of these studies may be divided into three stages which can be grouped together: preventing stage, acute stage and post-discharge stage. The focus of attention in the preventing stage is generally on a high-risk population. Other stages focus on both stroke patients/survivors and related to the person, e.g. family/relatives and friends.

Firstly, there are issues of stroke prevention and epidemiological studies of stroke with regard to the preventing stage. For example, Chien et al. (2010) created a model for predicting stroke events in Chinese people from 7 significant risk factors for stroke, i.e. age, gender, family history of stroke, atrial fibrillation, diabetes, systolic and diastolic blood pressure. Ezekowitz et al. (2010) reported long-term prevention of thromboembolism for stroke prevention in atrial fibrillation by using oral anticoagulants. Kelly-Irving et al. (2010) studied knowledge and awareness of risk factors for stroke in the French West Indies and made helpful suggestions for creating health promotion strategies. Khawnate et al. (2012) claimed that restricted blood pressure control was a useful method for preventing stroke events in hypertensive patients. There are many epidemiological studies which were concerned about the factors determining and influencing the distribution of stroke and other health-related stroke events such as prevalence studies (Oh et al. 2012; Poungvarin 2007; Venketasubramanian et al. 2005), incidence studies (Groppo et al. 2012; Prasad and Singhal 2010), aetiology (Dharmasaroja et al. 2011; Docu-Axelerad and Docu-Axelerad 2012; Hsieh et al. 2012; Tan et al. 2010) and stroke risks (Bandaru et al. 2009; Bi et al. 2010; Greisenegger et al. 2011; Lipska et al. 2007; Putaala et al. 2012; Siegerink et al. 2011; Spengos and Vemmos 2010; Zhang et al. 2012).

Secondly, the acute stage is associated with studies focusing on clinical investigation, treatment and effect of stroke on stroke patients and carers. For example, Putaala et al. (2013) found that there was a significant relationship between the high level of high-density lipoprotein (HDL) and small infarct size in the brain which was associated with better functioning outcomes in young adults with ischemic stroke. A study by Bigi et al. (2011) drew a comparison between children and young adults suffering from acute ischemic stroke. They found that the severity of stroke, clinical

outcome and mortality among children were similar to a group of young adults. Masskulpan et al. (2008) stated that stroke patients with no anxiety and depressive symptoms have improvement in functional ability and quality of life. Mak et al. (2007) studied the needs of family carers of stroke survivors before and after discharge and found they were related to emotional and psychological problems and family financial difficulty. A study by Greenwood and Mackenzie (2010) showed that anxiety was indicated as an important emotional outcome of stroke carers in early stages after discharge.

Thirdly, many studies of stroke outcome at the post-discharge stage are interested in stroke survivors' and carers' quality of life affected by stroke events (Jaracz and Kozubski 2003; Larson et al. 2005; Muus and Ringsberg 2005; Singhpoo et al. 2009; Sturm et al. 2004). For example, Widar et al. (2004) stated that long-term pain after a stroke relates to a lower quality of life among stroke survivors. Visser-Meily et al. (2009) studied the quality of life of stroke survivors and found that depression, anxiety and fatigue were strongly associated with a reduction in quality of life. A systematic review of outcomes in stroke carers by Greenwood et al. (2008) illustrated that the majority of studies paid attention to carers' emotional well-being and looked at issues of burden, quality of life and stress.

The focus of this thesis is connected with the post-discharge stage of the stroke trajectory, also called the stroke recovery stage. As described earlier, the effect of a stroke on a stroke patient is based on the severity of brain injury, the affected brain region and pre-existing health conditions. Stroke can cause dysfunctions in the stroke survivors' motor, sensory, mental and cognitive systems after the event (Stroke Association 2012a). Among stroke survivors some of them may be discharged from acute care hospitals with no disability, whereas others may leave with minor, moderate or severe disability. Stroke survivors with disability will inevitably face the stages of recovery which vary in length of time depending on the seriousness of brain-cell damage (Arayawichanont 2010; Hoffmann et al. 2003; Mant 2011; Stroke Association 2012b).

The rehabilitation phase is very important for stroke survivors to regain lost ability and to achieve the best possible recovery. Around Thailand, there are 14 public tertiary hospitals/facilities where interdisciplinary rehabilitation teams are available to provide neurological patients with inpatient rehabilitation programmes (Kuptniratsaikul et al. 2009). There are only some stroke survivors transferred directly from the acute care hospital to clinical rehabilitation facilities due to limited availability of inpatient rehabilitation facilities, (Dajpratham et al. 2009), and the majority of stroke survivors who can access those rehabilitation facilities are people who live in urban areas (Manimmanakorn et al. 2008).

For people who live in rural areas, the community rehabilitation services following the acute stage of stroke recovery are established and broadly provided in Western countries (Kalra 2010). By comparison, there is a shortage of stroke rehabilitation teams in the community in Thailand (Oupra et al. 2010). Although rehabilitation programmes such as outpatient programmes and home-based programmes are created and implemented (Sangngam 2006), public health systems to address and provide those programmes for stroke survivors and carers in rural communities are still lacking. Kuptniratsaikul et al. (2008) found that over 80 percent of survivors return to their own home for ongoing recovery. Primary carers play a major role in supporting and rehabilitating stroke survivors at home (Baumann et al. 2012; Rosenburg et al. 2009). In this context, home rehabilitation seems to be informal (Jullamate et al. 2006). Carers appear to be the key person to enhance stroke survivors' recovery.

A stroke may leave stroke survivors with harmful effects and/or permanently disabled in all age groups (Stroke Association 2012b). However, the impact of stroke on younger adult stroke survivors is notably associated with family and social life including employment issues. The impact may likely be different from older people due to increased lost potential life and the years of longer expected survival in younger age group (Marini et al. 2011). The maximum improvement of stroke survivors' physical ability to perform daily life activities is usually measured at six months after stroke (Mant 2011). This implies that a person with physical

impairment caused by stroke might have a slight improvement in physical ability or remain in the same condition after six months have passed. Therefore, it is reasonable to use a fixed point of six months after the onset of stroke to be the starting point for recruiting stroke survivors and carers as participants in this study.

2.2.3 Stroke and disability

Disability is defined through distinct models, the medical model and the social model (Watson and Denney 2009). From the traditional medical aspect, there are different meanings between the words 'impairment', 'disability' and 'handicap'. However those words have often been used interchangeably (Mung'ala-Odera and Newton 2007). The International Classification of Impairments, Disabilities, and Handicaps (ICIDH) was introduced by the World Health Organization (WHO 1980). The definition of the term 'impairment' involves physical aspects which directly affect body function or body structure, memory, consciousness and the senses. Disability is defined as lack of ability to do an activity resulting from an impaired organ, while handicap is a result of impairment or disability in relation to social matters and culture (Barbotte et al. 2001; Canevaro 2002; Pfeiffer 1998).

The definition of these three key words in the ICIDH was revised as the ICIDH-2 to include components of health, which focused on physical, mental and social well-being instead of the consequences of diseases based on the 1997 medical model (Pfeiffer 1998). In 2001, WHO announced a revision of ICIDH-2 to the International Classification of Functioning and Disability (ICF) for an individual's impairment linked to his/her social life (Mung'ala-Odera and Newton 2007). Thus, the ICF focuses on bodily functions, bodily structures and participation involving a life situation, activity and environmental factors (Canevaro 2002; Watson and Denny 2009), and it is widely used in 191 countries and translated into several languages (Chatterji et al. 2002; Masala and Petretto 2008).

For the medical model, disability is shaped and presented as an individual problem. It is a 'personal tragedy model' (Carson 2009: 7) because their impairment leads them

to not be able to undertake activities, to lack ability to look after themselves, to live dependent lives and to be unequal to the majority of people. People with impairments tend to stop taking part in social activities (Carson 2009; Watson and Denny 2009). They may feel uncomfortable in allowing themselves to be exposed to challenging social situations. This model has significance for my study because these findings and the degree of disability of stroke survivors might relate to stroke survivors' and carers' emotion work in their everyday living.

In order to recruit appropriate participants for my study, a measure of disability following stroke was required. The modified Rankin Scale (mRS) and the Barthel Index (BI) are commonly used to measure stroke patient outcome and disability (Cincura et al. 2009; Kwon et al. 2004). The mRS is an ordered scale for measuring motor function and has six grades from total independence (grade 0) to dependence at all times (grade 5) (see also page 15). It is used in acute stroke trials and outpatient assessment (Howard et al. 2012; Qureshi et al. 2012). The BI which assesses the ability to perform basic daily living activities consists of 10 items, i.e. feeding, bathing, grooming, dressing, toilet use, transfers from bed to chair and return, mobility on level surface, climbing stairs, continence of bowels and bladder (Mahoney and Barthel 1965). The BI scores range from 0 (total dependence) to 100 (independent). It can be used for evaluating a baseline physical function and monitoring an improvement in stroke survivors' activities of daily living over time (Parks et al. 2012; Uyttenboogaart et al. 2007).

I decided to use the mRS for measuring physical disability in order to meet the criterion for inclusion of stroke survivor participants in my study for the following reasons. Firstly, the mRS is well known for assessing global outcome after stroke. Many published studies use the mRS to classify stroke severity (Bigi et al. 2011; Putaala et al. 2013; Rist et al. 2010; Singpoo et al. 2012; Zhang et al. 2010). Secondly, there are many tasks besides the 10 items of the BI which may determine disability after stroke in daily living, e.g. cooking, driving and working (Uyttenboogaart et al. 2007). Measuring disability by the mRS can cover those tasks. Thirdly, Quinn et al. (2009b) reported that the overall reliability of the mRs is rated

on a moderate level. Although the mRS has been criticised as a sensitive scale, the reliability of the mRS can be improved by using a structured interview (Banks and Marotta 2007; Janssen et al. 2010; Quinn et al. 2009a; Shinohara et al. 2006; Wilson et al. 2002, 2005). Finally, the mRS is not complicated to use when assessing stroke disability in the recovery stage, and as I was trained to use the mRS while working in hospital this should improve reliability of application.

For the social model, disability refers to unequal opportunities for involvement in social activities with other people resulting from physical limitation and social barriers (Thomas 2004; Watson and Denny 2009). Carson (2009) argued that because there is often little or no consideration given to disabled people who need to be involved in an activity with others, disability can be understood as an unfair situation through which people with impairments are prevented from connecting to society. From the definition and description above, the term 'disability' is entirely different from 'impairment' and implies barriers to accessing full potential to participate in society (Kelley-Moore et al. 2006).

Nowadays, there is a political shift in relation to promoting an equal relationship in society for people worldwide. This policy has also led to an encouraging response to people with impairments. In order to increase equal opportunities for access to social situations such as information, education, employment, transportation and public events, campaigns for anti-discrimination legislation, equal-opportunity policies, positive action programmes, independent living and the formation of new self-organised groups have arisen (Carson 2009; Thomas 2004; Watson and Denny 2009). Therefore, the way of thinking about disabled people through the social model is that impairment becomes a part of everyday life. It is essentially a social problem, which societies and social arrangements need to change.

In Thailand, there are many policies for making an effort to keep people with impairments equal and free (Murray 1998; Pozzan 2009). "Disabilities allowance of 500 baht per month, regulation of the promotion of education for persons with disabilities, the regulation on the employment of persons with disabilities (1 disabled

person to every 100 regular employees), and the regulation on the sign language service, which enables deaf people to ask for the service 24 hours a day for medical and health services, job applications, lodging complaints or other services" (Piromya 2010: 1) are currently in force.

In summary, my study focuses on disability which is attributable to stroke mainly in terms of the relationship between stroke survivors and carers who are involved in interpersonal interactions and social situations resulting from physical impairment. The meaning of disability relates to medical and social models. I use both concepts to approach stroke survivors. The medical model indicates the group of people to be studied. The sense-making idea is based on the social model in order to highlight my idea about the equality of human beings in society through an ethnomethodological perspective which will be discussed in Chapter 3. Moreover, many studies have considered different aspects following stroke. However, there is a lack of research on stroke survivors' and carers' emotion work. The literature about the emotional experiences of care after stroke in connection with interpersonal relationships and social interaction does not cover the issue of what is the nature of emotion work among stroke survivors and carers and how they understand emotion work in everyday lives.

2.3 Emotion Work

As a result of a stroke event, stroke survivors and carers may experience profound effects on many aspects of their lives. The unique situation for them is commonly linked to the management of feeling during their daily living activities. Emotions and feelings displayed by stroke survivors and carers may become important for improving one another's life satisfaction. As explained in Chapter 1, I am interested in emotion management at home and identified a lack of research into the field of emotion work regarding interpersonal relationships between stroke survivors and their carers. I therefore based my study on Hochschild's work (Hochschild 1979, 1983) which emerged from my review of the literature as a key conceptual framework to understanding the emotion work and feeling rules required by stroke

survivors and carers. According to feeling rules, the issues around Thai culture and the social situation are also provided. A discussion on the relationship between emotion work and emotional labour is presented. Research into emotional labour and explanatory data on emotion work in families are discussed. Some of these, mainly qualitative research studies, include descriptions of emotion work in several contexts.

2.3.1 Defining emotion work

Sociological studies of emotion aim to discover how emotions are shaped by cultural and social norms. It is different from the studies of human emotions through psychological or biological approaches which seek to explain and understand human behaviour through a focus on individuals' mental process, emotional experiences or the biological basis of behaviour (Garey and Hansen 2011). A theoretical perspective on the study of emotion has been taken through symbolic interactionism which is individual's personal meaning (Fields et al. 2010). The perspective is based on how people construct their realities and symbolise common meanings in relation to social situations (Denzin 1969).

Kemper (2000) stated that Hochschild is a sociologist who has a particular interest in emotion and self-identity, and the main focus of the symbolic interactionist theories is on the respective influences of culture and identities which "represent commitment to social roles" (Wisecup et al. 2007: 109). Hochschild explained that "emotion is open-ended" (Hochschild 1983: 206), and that "social factors enter not simply before and after but interactively during the experience of emotion" (Hochschild 1983: 211). This suggests that emotion is an interactional accomplishment underpinned by influential social forces, and the development of emotion may be encouraged in several ways. It implies that the way individuals respond to given situations has been linked to socialisation and the result of their emotional experiences. Therefore, an emotion is a symbol of how individuals interact with other people in a particular social situation. The nature of social interaction influences individual emotions. Hochschild describes the meaning of emotion as follows:

> I define ‘emotion’ as bodily cooperation with an image, a thought, a memory- a cooperation of which the individual is usually aware. I will use the terms ‘emotion’ and ‘feeling’ interchangeably, although the term ‘emotion’ denotes a state of being overcome that ‘feeling’ does not (Hochschild 2003: 87).

According to an excerpt above, the use of the terms ‘emotion’ and ‘feeling’ can be exchanged, although the definitions of ‘emotion’ and ‘feeling’ can be distinguished (Hochschild 1979). The term ‘emotion’ includes a cultural display of feeling and evaluations of a phenomenon (liking/disliking). Emotion is usually linked to physiological changes, and hormone and neurotransmitter release. The term ‘feeling’ denotes the experience of physical sensations, and subjective experience of emotional states. On the basis of these definitions, emotions can be differentiated from feelings such that individuals can express either a real or pretended emotion (Shouse 2005; Thoits 1989).

The definition of ‘emotion work’ is “the act of trying to change in degree or quality an emotion or feeling” (Hochschild 2003: 94). In addition, it refers “to the act of evoking or shaping, as well as suppressing, feeling in oneself” (Hochschild 1979: 561). This means that ‘evocation’ and ‘suppression’ are central to the emotion work perspective. The focus of evocation is on individuals’ attempts to create an image of desired feelings into their minds, and the focus of suppression is on individuals’ attempts to decrease undesirable feelings or to prevent themselves from expressing the feelings (Hochschild 2003). Pfeffer (2010) argued that emotion work integrates personal perspectives with social regulation, and it is placed on the desirability of expressing individuals’ feeling caused by his/her own emotional experience (Kemper 2000). Hochschild indicated that “emotion work refers to the effort- the act of trying- and not to the outcome, which may or may not be successful” (Hochschild 2003: 95). It means that the theory of emotion work highlights the process of doing emotion work instead of its outcome. It also values the lived experience.

There are two different forms of self-managing of affective displays: surface acting and deep acting. Hochschild defined surface acting as a process whereby “we deceive others about what we really feel, but we do not deceive ourselves”, and deep

acting "involves deceiving oneself as much as deceiving others" (Hochschild 1983: 33). These forms are compatible with display rules according to which members of societies are expected to perform socially acceptable behaviour through the expression of positive emotions and suppression of negative emotions in a certain situation (Diefendorff et al. 2011; Scott and Barnes 2011). For the strategy of both forms, individuals can produce the appropriateness of emotional displays, but the particular way of managing their inward feeling is different.

The accomplishment of surface acting is that individuals consciously change external expression of feelings to mask or hide their actual feelings which may or may not match an outer presentation. Surface acting leads to a faked display of socially appropriate emotions. For surface acting, the individuals realise what they feel and what they should feel in a given situation. They try to adopt outward appearances in order to induce a correspondence between inward feelings and outward appearances or the strategy to regulate feelings from outside to inside. On the other hand, an appropriate expression of feelings shown by undertaking deep acting results from regulating inner feelings. For deep acting, the individuals attempt to produce a proper state of emotion by changing the state of mind from inside to outside. This strategy makes a display of genuinely felt emotions (Dickson-Swift et al. 2009; Groth et al. 2009; Judge et al. 2009; Pisaniello et al. 2012).

Regarding deep acting, Hochschild (1979) identified cognitive, bodily and expressive techniques required for managing one's feelings which may then be used together in practice. Cognitive techniques involve altering image, ideas or thoughts in relation to emotional experience. Bodily techniques are to make physiological change of feeling. An endeavour to change external expression of feeling refers to expressive techniques of emotion work. However, all techniques are an attempt to change one's own feelings directly (Keys 2005). Therefore, emotion work is the emotional management process by which individuals evoke and suppress feelings through the use of emotion work techniques. The process of emotion work may be a way of making an effort with their feelings and emotional expression. The process involves self presentation through socialisation which can be learned through interactions with

others. People can work on and create their inner feelings in order to portray an acceptable expression in a given situation.

2.3.2 Emotion work and emotional labour

The terms 'emotion work' and 'emotional labour' are used interchangeably in reported studies (Hunter 2001; Knights and Surman 2008; Lewis 2008; Lewis 2012; Williams 2012; Zapf 2002). Hochschild (1983) described the concept of emotion work as associated with the definition of emotional labour:

> I use the term emotional labour to mean the management of feeling to create a publicly observable facial and bodily display; emotional labour is sold for a wage and therefore has exchange value. I use the synonymous terms emotion work or emotion management to refer to these same acts done in the private context where they have use value. (Hochschild 1983: 7)

The focuses of the definition of emotion work and emotional labour described above have mainly been on three issues. The first one is an intrapersonal issue emphasising the act of controlling inner feelings. This issue focuses on how individuals feel, how aware they should feel, how they wish to feel, how they try to feel and how their feelings themselves are classified (Kemper 2000). The second one is an interpersonal issue relating to how individuals express appropriate feelings in public. This may be done for maintaining personal relationships and self-image or receiving social approval (Rietti 2009). The first two issues demonstrate the process of achieving emotion work, and for which individuals work in the same way as when undertaking emotional labour.

The third issue concerns the distinction between the concepts. This is to connect with the matter of place and value. Emotional labour occurs in sectors of paid work, e.g. hospitals, hotels and market places which are covered by the organisation's rules and regulations, whereas people who encounter emotion work are in unpaid working situations, i.e. informal carers and family members. Emotion work happens in private places and personal life (Hochschild 1983; Smith 2012). McClure and Murphy (2007) stated that although the process of undertaking emotion work and emotional

labour are defined through the same concepts, their constructs differ. Emotional labour has exchange value: here individuals give emotional labour in exchange for a wage. In the context of emotion work and the nature of its use value, individuals produce emotional response behaviours for reasons of sustaining their lives (Hochschild 1983). In practical terms 'emotion work' may not be completely interchangeable with 'emotional labour' because they are characterised by a significant difference in the quality of the contexts and in the essence of value (McClure and Murphy 2007). This implies that these two terms can be used interchangeably only when talking about process.

2.3.3 Feeling rules

An expression of emotion is one method for human communication. Research by Ekman found that "basic emotions are universal and innate" (Evans 2001: 5). The expressions include joy, distress, anger, fear, surprise and disgust (Ekman 1982; Evans 2001). It implies that individuals can automatically understand basic emotions and show their feelings in the same way, regardless of cultural association. Despite this, the focus of Ekman's study was not on looking beneath the surface appearance of emotions as he argued that "the studies tell us nothing about the subjective feelings behind those expressions" (Evans 2001: 7). Individuals' facial expression may or may not correspond to their actual feelings. Therefore, facial expression is not adequate for determining what individuals feel. Understanding the expression of emotions should be considered not only from facial movement, but also through the tone of voice, eye contact and nonverbal behaviour (Scherer and Brosch 2009).

Although emotions occur naturally, people from different cultures might have different senses of emotions and may give a different emotional reaction in a given situation (Evans 2001; Scherer and Brosch 2009). Different cultures influence emotional expression differently motivated by self-enhancement (Imada and Ellsworth 2011). "Self and society are two sides of the same coin" (Fields et al. 2010: 156). This suggests that social conventions and culture norms influence human emotions and identities and vice versa. Culture may have the power to affect

people's mind by giving them a social line on how they should feel and often try to feel.

One of the central concepts in Hochschild's emotion work perspective is feeling rules which refer to the agreement in social and cultural norms (McCoyd 2009). Hochschild asserted:

> Feeling rules define what we imagine we should and shouldn't feel and would like to feel over a range of circumstances; they show how we judge feeling...A feeling rule governs how we feel...When we judge a feeling as inappropriate, we actually apply one of three measuring rods we can see as types of appropriateness: (a) clinical appropriateness refers to what is expectable for normal, healthy persons (the person may think her/his anger "healthy" even if it's morally wrong); (b) moral appropriateness refers to what is morally legitimate (the person can get furious at a helpless child, but this may be morally inappropriate); (c) social-situational appropriateness refers to what is called for by the norms specific to the situation (e.g., to feel effervescent at a party) (Hochschild 2003: 82).

From the excerpt above, feeling rules refer to the appropriateness of feelings in an expectation of any situation-specific scripts which concern duration, direction and intensity (Hochschild 1983). Individuals actively take part in their emotions which relate to self-consciousness. The individuals may experience various feelings and judge whether or not those experiences are right for a particular context (d'Oliveira-Martins 2012). Feeling rules are "the scripts or moral stances that guide our action" (Smith 1992: 7). It appears that feeling rules are constructed by social regulations, cultural norms and morality. The rules can frame how people generally feel and express their feelings in a proper way (Fields et al. 2010). For example, individuals are expected to feel happy at a party and sad at a funeral. If they do not have such feelings similar to the norms which suit these situations, they may feel uncomfortable or frustrated and try to change how they should feel and try to work on their feelings for appropriate expression of feeling. It implies that the individuals are socialised to follow feeling rules which are closely associated with cultural beliefs and accepted social norms. Therefore, the understanding of culture as a pattern of everyday living in social membership may help to identify the set of feeling rules in each social group.

Hochschild (2003) illustrated that some feeling rules may be identified as global rules. For example, individuals should not abuse a human being. Some rules may exist in particular groups. The rational mind and the emotional body are traditionally separated in Western culture, whereas thoughts and feelings are entwined in the Eastern perspective (Huynh et al. 2008). Culture is central to human beings in the way of "how self should relate to others" (Mosquera et al. 2004: 193). From these perspectives, there is a clear distinction between feeling rules in western and eastern regions and in any particular social groups on the basis of their beliefs, social norms and cultures.

In Thailand, Buddhism has a significant influence on the way of life and is involved in traditional values and cultural activities of Thai people (Ministry of Culture 2008). More than 90 percent of Thais are Buddhist of which Theravada or Hinayana Buddhism is the majority of Thai Buddhists (Chamratrithirong et al. 2010). The key Buddhist principles are to lead a moral life and make peace (Chareonla 1981) through keeping mental balance (Ekman et al. 2005). Thai Buddhists have been taught to believe in the law of 'karma' and the concept of reincarnation which entwine with each other (Chamratrithirong et al. 2010; Craft 1999; Pinyuchon and Gray 1997; Sivaraksa 2002).

An understanding of karma is necessary to learn principal Buddhist doctrines. The words 'karma' and 'kamma' may appear in different sources. It is important to provide general information about the difference between these two words for avoiding confusion. Karma and kamma have the same meaning. The former originates from Sanskrit language. The latter comes from Pāli language (Shaw 2006). However, I have decided to use the word 'karma' because it is directly translated from Thai language. The concept of karma represents "the law of cause and effect" (Pinyuchon and Gray 1997: 210). Among Thai Buddhists, karma is understood as action and the result of the action (Mokkhabalarama 1988). This means that individuals will experience the result of their behaviour (meritorious or sinful acts) either in current or future lives.

In brief, karma is broadly divided into two separate types, good karma and bad/evil karma (Bun and Bap, Thai language). It relates not only to individuals' physical acting but also to how they think and say words. In common practices for lay Buddhists, they are expected to follow the observation of the Five Precepts founded on the prohibitive articles which include abstaining from killing, stealing, sexual misconduct, telling falsehoods and the consumption of alcohol and intoxicants. In Thai Buddhism, one of karma doctrines is that nobody can act to prevent the result of karma (deeds) and to escape from its power. This doctrine is related to the belief in reincarnation (the cycle of birth and death or a never-ending life) that the beginning of one's life is not birth, and the ending of life is not death. After death, an individual is reborn into a different body, which may not be a human being. The circle of birth and death will continue on one's life again and again. Each circle is also connected to other lives. Merit making (Thum-Bun, Thai language) is a way to enhance good karma leading to a good life. Thai Buddhists can make merit by, for example, going to the temple to worship Buddha, offering food to monks, taking part in Buddhist ceremonies, making donations, praying to Buddha and following the Buddha's teachings. However, the highest fruit of karma, which is the greatest achievement for peace and happiness, is the ending of karma, nirvana, which means a state of life which is without being controlled by life suffering (Cook 2010; Klunklin and Greenwood 2005; Limanonda 1995; Mokkhabalarama 1988; Pinyuchon and Gray 1997; Shaw 2006).

There are various acceptable performances within Thai societies influenced by Buddhism. For example, younger people have great respect for all those who are older. Children owe their parents a great debt of gratitude (Charnsri 2008; Ministry of Culture 2008). Therefore, showing gratitude is also a way to do a meritorious act to improve good karma. The issue of family relationship will be discussed in the section on rural Thai families (see below).

In summary, feeling rules are determined in part by what individuals learn about social sentiments constructed by culture and social structure. Culture plays a critical role in defining individuals' emotional experiences in everyday lives, and it is an

important element in the emotion work process. Feeling rules highlight the importance of culture in connecting social identities to a suitable emotion in a particular social situation. The individuals may utilise their lived experiences as guidance on how they should feel to meet a normative standard. It is shown that the process of succeeding in emotion work is to reach an agreement between feeling rules and what individuals try to feel in order to avoid dissonant feelings.

2.3.4 Emotional labour in nursing

Emotional labour is a part of work regulation that demands people behave publicly in pleasant ways. Three characteristics of emotional labour are as follows: "face-to-face or voice contact with the public; it requires the worker to produce an emotional state in another; it allows the employer through training and supervision to regulate a degree of control over the emotional activities of workers" (Smith 1992:7; see also Hochschild 1983). A number of researchers have examined emotional labour in studies of work and organisation (Wharton 2009), e.g. teachers in primary and secondary schools (Philipp and Schüpbach 2010), store employees and managers (Liu et al. 2008), service employees (Pugh et al. 2011), bank tellers (Sliter et al. 2010), flight attendants (Chang and Chiu 2009; Hochschild 1983), hairstylists (Cohen 2010), family support workers (Gray 2009a) and employees in service sectors of various organisations (Cheung and Tang 2009; Judge et al. 2009).

These studies highlight employees' mental health outcomes. Physical and psychological strain, stress, burnout and emotional exhaustion, as negative consequences of performing emotional labour for employees are described (Chang and Chiu 2009; Rantanen et al. 2011; Sliter et al. 2010). Liu et al. (2008) defined the requirements of emotional labour as a stressor. However, there are many studies which report positive outcomes of emotional labour strategies. For example, Philipp and Schüpbach (2010) reported that teachers who used deep acting felt less emotional exhaustion than teachers who performed surface acting after a one year period. Cheung and Tang (2009) found that emotional intelligence (EI) related to emotional labour. EI includes "the ability to perceive emotion accurately; the ability

to access and generate feelings when they facilitate cognition; the ability to understand affect-laden information and make use of emotional knowledge; and the ability to manage or regulate emotions in oneself and others to promote emotional and intellectual growth and well-being" (Salovey et al. 2008: 535). EI influenced individuals to use deep acting for understanding and managing their own and others' emotions. EI is an emotional resource leading to high levels of deep acting (Liu et al. 2008). It suggests that the engagement in deep acting may affect employees' emotional well-being in the workplace.

Emotional labour has also been applied to the study of nursing (Gray and Smith 2009). The image of nursing is still seen as women's work and a natural female quality (Smith 1992; Gray 2009b). Smith (1992) is the original researcher who applied the idea of emotional labour to nursing studies. She explored the study of emotional labour in nursing students and the role of lecturers and mentors in effectively supporting students to learn to care (Smith and Gray 2001). Emotional labour becomes "an important part of the role of health-care professionals" (Mann 2005: 305). The notion of emotional labour is taught and integrated into nursing work so that nurses provide holistic care rather than services for patients. For nurses, emotional labour is included in both personal and professional development. Nurses can be encouraged to learn to manage complex emotions which are a link between their personal and social identity (Theodosius 2008).

Research on emotional labour in nursing shows enormous potential for the development of caring practices in nursing (Wharton 2009). Emotional labour is a vital part of the quality of care among nurses, healthcare professionals as well as students (Gray 2009b). Numerous studies have attempted to explain the relationship between emotional labour and nurses' work. For example, nurses used emotional labour for managing their own emotions and supporting others' emotions, so that they can maintain relationships with patients and their relatives, and also colleagues (Gray and Smith 2009; Gray 2009b). Ross and Glass (2010: 1408) reported that nurses identified emotional labour as the energy required for providing quality in palliative care. Emotional labour is described as a requirement of professional

standards for nurses who care for families in the intensive care unit (Stayt 2009). Huynh et al. (2008) found that the positive consequences of emotional labour in nursing studies involve increases in the sense of personal and professional accomplishment, the improvement of nurse-patient relationships and job satisfaction, whereas the negative consequences are job-related stress, emotional strain, self estrangement, burnout and depersonalisation. Therefore, it is necessary for nurses to have a supportive environment to enable discussion about emotional labour issues.

The findings of previous nursing studies in emotional labour illustrated that surface acting produces a more deleterious effect on well-being than deep acting (Judge et al. 2009). For example, the surface acting form and the act of negative suppression of emotions led to job dissatisfaction and the predictive outcomes of negative health and psychological well-being among South Australian hospital nurses (Pisaniello et al. 2012). Haycock-Stuart et al. (2010) found that community nurse leaders reported the experience of stressors as emotional injury when they failed to manage their emotion. They undertook emotional labour to maintain good relationships with patients and colleagues. Huynh et al. (2008) reported a concept analysis of emotional labour in nursing in which the adoption of a work persona is seen as part of the process of performing emotion work during encounters with patients. It implies that emotional labour is valued and recognised as one of the caring components of nursing.

Furthermore, emotional labour and emotion work may be undertaken together in paid work. For example, Bolton (2000) found that nurses work hard on emotional labour within work environments guided by nurses' feeling rules. They must maintain their professional face as a job requirement. In the meantime, they undertake extra emotion work when they provide actual caring behaviours to patients as a gift. The gift, which nurses use in a given situation at work, might lead to understanding of how they achieved emotion work guided by personal feeling rules that free them from the organisation's regulations and professional requirements.

I picked the topic of emotional labour in nursing for this thesis because it draws on my personal background in community nursing and my experience as a stroke carer in a family home. Furthermore, the research approaches and methods used in the area of emotional labour in nursing appear to be applicable to the study of emotion work in the home environment. Research on emotion work with a particular focus on its contributions to families, household work and care is discussed in the following section.

2.3.5 Emotion work in families

The family is defined as "a self-identified group of two or more individuals whose association is characterised by special terms, who may or may not be related by bloodlines or law, but who function in such a way that they consider themselves to be a family" (Whall 1993: 4). Emotions at home related to "the foundations of a social expression of emotion in the privacy of the domestic domain" (James 1989: 15). Emotion work involves family lifestyle as a vital part of family work, gender and marital satisfaction (Erickson 2005; Fields et al. 2010; Hochschild 1989; Smith 2012).

Undertaking emotion work is often reserved for women on account of its association with female characteristics. According to Hochschild (2003: 104-107), there is an unequal relationship between a husband and wife in a family because of cultural ideas about manhood and womanhood. Although many wives go out to paid work, most husbands do not fairly share or do household work because housekeeping responsibilities and looking after children are traditionally held to be women's work. The 'economy of gratitude' becomes poor or rich depending on how a shared marital baseline exists in the family. The economy of gratitude is also linked to how a change in the role of gender and economic power is understood between male and female. Both the economy of gratitude and the marital baseline may be perceived differently in an individual sense and in terms of their emotional possibilities within the family home (Fields et al. 2010; Minnotte et al. 2010a).

Wharton and Ericson (1995) stated that women have importance as providers of emotional support within the family. In particular, a woman who works outside the home may do twenty-four hours of work including housework and care work, taking care of everyone in her home, and this work at home has been called the second shift (Hochschild 1989: 4); she also has a third shift for emotion management. Women may face strong feelings such as stress, depression and anxiety when difficult situations arise. For example, a mother who looked after her ill child experienced the suppression of emotions (Clarke 2006). In this situation, they were burdened with not only an increase in physical work in the family home, but also in carrying out emotion work during caring interactions. Prawtaku (2006) studied role strain and the need for help in family carers in Thailand and found that a carer provides care and interacts with stroke survivors around 7-19 hours a day at home. This may also involve the long-term expressive suppression of certain emotions in their everyday lives, both negative and positive emotions (Rietti 2009).

The concept of emotion work has been widely applied to the study of work and family issues (Garey and Hansen 2011). For example, emotion work played a part in the long term recovery post flooding in Hull, UK. It played an important role in managing participants' emotions during the process of disaster recovery (Whittle et al. 2012). Smith and Steck (2006) found that emotion work was carried out by pregnant women during graduate school when they interacted with other graduate students, advisors, employers, and other faculty members. Pfeffer (2010) from in-depth interviews with fifty women partners of transgender men, revealed highlights in tensions and inequalities in everyday family practices. An understanding of the literature indicates that emotion work is involved in family activities and reveals that individuals usually work on their feelings in everyday experience.

In summary, emotion work is commonly used to describe unpaid activities which have use value and take place in private contexts (Hochschild 1979, 1983; Smith 2012). Several studies explicitly associate an impact of stroke with psychological burden for both stroke survivors and carers (Berg et al. 2005; Das et al. 2010; Haacke et al. 2006; McCullagh et al. 2005; Thomas and Lincoln 2008). The literature

on stroke and emotion work suggests that emotion work may go unseen through various routine caring tasks involved with ordering everyday life among stroke survivors and carers. Emotion work may affect their quality of life and emotional well-being.

2.4 Cultural values in Thai family ideology

People in different countries have different characteristics. The way of thinking, beliefs, and values of people may be affected by potential cultural factors (Dilworth-Anderson et al. 2002). Research by Knight and McCallum (1998) found that the cultural values of different ethnicities affected the particular opinions, thoughts or beliefs that the group of people have. Therefore, it is very important to consider the differences between Eastern and Western philosophy for understanding Thai cultural context. There are a number of research reports to explain the differences. For example, philosophical ontology between China and the west developed from different modes such that "Chinese philosophy is to conform to reality, while Western philosophy is to change reality" (Jingshan 1983: 271). In Western cultural contexts, people value independence and individuality. By contrast, interdependence and maintenance of interpersonal harmony are highly valued in Eastern cultural contexts (Markus and Kitayama 1991). Therefore, Western people behave in a way which expresses their confidence and individuality, whereas Eastern people perform "interdependence-promoting behaviour" (Ashton-James et al. 2009: 341).

The components of emotion comprise "(a) appraisals of a situational stimulus or context, (b) changes in physiological or bodily sensations, (c) the free or inhibited display of expressive gestures, and (d) a cultural label applied to specific constellations of one or more of the first" (Thoits 1989: 318). The first three components appear to be influenced by culture. Culture has effects on how individuals recognise, label, appraise, manage and, express a feeling (Hochschild 1998: 11). Thus, to explore the nature of emotion work, it is necessary to know cultural backgrounds and the cultural contexts of each specific group of people in

order to understand the beliefs which underlie the ways they think, behave and feel in everyday affairs.

Thai culture is mainly influenced by Buddhism (Ministry of Culture 2008). Everyday living for Thai people is affected by Buddhist values, e.g. the wedding ceremony, the new home ceremony and the funeral. The key Buddhist principles are to lead a moral life and make peace (Chareonla 1981). Thai Buddhists believe in the nature of cause and effect through the law of karma and try to keep a mental balance in day-to-day life (Ekman et al. 2005). The beliefs are derived from karma, as regards merit and demerit. Many Thai people think that merit making brings them to happiness and satisfactory life both in the present and in the next reincarnation. They also believe that doing good things always brings them good chances in their present and future lives. People who perform a bad thing or think about something bad for others will receive some painful situation eventually (Cook 2010; Mokkhabalarama 1988; Payutto 1993; Vongvipanond 1994).

Furthermore, Thai people have great respect for hierarchical relationships. Thai families are a hierarchy with the parents at the top (Ministry of Culture 2008). The young are taught to admire elders in the family and listen to their advice. Children always honour their parents and thank them for nourishment, love, time, money spent for education and everything that parents provide them. 'Ka-Tan-Joo' (Thai language) means deep gratitude which appears to be the first qualification of a good person. This is like a sense of responsibility which is a fixed belief and an idea cultivated since early childhood (Srivichit 2007; Vongvipanond 1994). Having a feeling of gratitude to parents and a person who does good things for you, means you have a duty to take care of parents, a partner and other family members to cope with severe illness or difficulties in later life at home rather than taking them to a nursing-home, and you also have the greatest respect for all those who are older than you (Charnsri 2008; Ministry of Culture 2008). Therefore, when someone in the family falls sick, a person in the family will be willing to be a main carer, and other family members will also provide associated care (Jullamate 2006; Prawtaku 2006; Sangngam 2006). For Thai people, these are strong beliefs, and such methods are

ways to return a good thing to their parents and benefactors related to Buddhist values.

To obey a rule and to do things in a traditional way are always part of education among Thai people (Ministry of Culture 2008). For example, seniority is very important. This means that the oldest person is revered. His/her opinion and advice, including non-verbal communication, should be respected. Moreover, people should not express strong emotions, e.g. anger, and shout at others especially people who are older than you. Respect for others is necessary because it is impolite to show strong opinions about other people (Chareonla 1981; Intachakra 2012). Living together in harmony and psychological well-being are central to Thai people's minds (Vongvipanond 1994).

In summary, there are differential thought patterns regarding everyday lifestyle between people in Western regions and Thais based on norms, local customs, beliefs and their own culture. In Thailand, Buddhism is a powerful influence on culture which is significantly associated with a self-concept of morality. Morality contributes to the maintenance of social order and social reality (Stets and Carter 2012). It appears that cultural expectations and shared common rules for moral behaviour and moral emotions influence individuals to act or feel in a particular way during interactions within a given situation. Respect of parents and elders and of a hierarchical system, a peaceful mind, and having morals regarding the action of moral values on behaviour and on feelings of guilt, embarrassment and shame, emerge as Thai people's display rules and feeling rules in general.

2.4.1 Rural Thai families

Viewed from a sociological perspective, the basic unit in societies is the family. A family lifestyle regarding age, gender, beliefs, social class, and economy is socially constructed (McKie and Callan 2012). Coltrane (1998) stated that the word 'family' does capture many things, and it is used to refer to many meanings, such as people, children, couples, partners, feelings, ownership, family values and households.

However, family is generally defined as a group of people who are related to each other by the institutions of marriage and parenthood (Baker 2001b). The different types of families are widely divided into two groups, nuclear family and extended family. The main feature of the nuclear family is an adult couple and/or their children, whereas several generations who live together in the same house whether or not they may be in a single household is the main feature of the extended family (Baker 2001b; Brown and Wilson 2009).

The family unit is still the cornerstone of both Western and Eastern societies. In the sociology of the western family, the autonomous nuclear family developed in the 1950s. It is comprised of just four roles: husband and/or father, wife and/or mother, son and/or brother, and daughter and/or sister (Featherstone 2004; Goldthorpe 1987; Silva 2010). In Thailand, although most Thai family structures are considered as nuclear family where everyday lives have been adapted slowly to the ideals of Western developed nations through globalisation, the extended family and old traditions can be found in rural areas (Ministry of Culture 2008). However, there is a strong, close bond in Thai family groups. The behaviour, customs and beliefs of Thai people today are still connected with traditional Thai culture (Srivichit 2007).

Smith (1973) has written a classic study about the family structure of 910 Thai peasant households. He found that the size of households was between three and thirteen persons, and about one-third of all cases were extended families. It appears that, in the past, the majority of Thai rural families were nuclear families. Recently, the National Statistical Office (2012) reported that average household size has slightly decreased from 3.8 in 2000 to 3.2 in 2010. This confirms that the significant structure of Thai households is the nuclear family. However, extended families are the common tradition of Thai family structures in rural areas. Although nuclear families are the largest in number, these families are located in the same area of close relatives' houses (Jongudomkarn and West 2004). People in these families are very close to their parents. They are able to contact and help each other at any time.

‘Sami Pen Chang Thao Nah, Panraya Pen Chang Thao Lang’ is an old Thai proverb representing the role of men and women in the family. The proverb means that the role of the husband in the family is compared with the front legs of an elephant, while the hind legs refer to the wife’s role. The National Statistical Office (2009) reported that sixty-six percent of Thai family leaders are male. Unlike a characteristic of family life in Western European countries where there is a noticeable decrease in wives’ economic and social dependency on husbands (Allan et al. 2001), a characteristic picture of rural Thai families shows a patriarchal structure where men are always the leader of the family and commonly work outside in order to make money for supporting family members. Women are in a supporting role and spend most of their time on household chores and providing informal care for family members (Fuller et al. 2004; Jullamate et al. 2006; Limanonda 1995).

Men hold a superior position over women due to the traditional productive roles of men for which agriculture is still the largest occupation in Thailand (the National Statistical Office 2012). In rural areas when the rice farming season arrives, the family leader, who is always a man, supported by other family members including women usually make up the source of labour for a process of cultivation which requires joint efforts to succeed. Men may do part-time work as a labourer in construction and undertake other work when they have some free time during and after this season (Walter 2004). Women may also work as construction labourers, factory workers and civil servants, but they always receive lower pay than men. Women’s work seems to be an additional income for the family. Therefore, the major income comes from men’s work, whereas the major responsibilities for doing housework and providing care for the family members at home are women’s work. These customs reduce women’s ability to earn their own incomes and/or to achieve stable incomes. From this description, women appear to depend on men for a living, and a woman’s ability to make decisions may be influenced by her husband and/or the family leader. Nowadays, women come increasingly into the labour market, and men seem to accept this situation (Mills 2005). Although the status of women in Thai society is quite high by comparison with many developing countries (Fuller et al.

2004), sexual equality is still problematic in the family home (Pinyuchon and Gray 1997; Jongudomkarn and West 2004).

In most of rural Thailand, the status of parents and older people in the family is still rather high. Children and family members always respect and support parents and older people (Pinyuchon and Gray 1997). Children may be brought up by their grandparents so the relationship between them is usually close. Knodel and Chayovan (2009) found that there were around 70 percent of rural adult children living with or next to their parents' home. These children were able to talk face-to-face and provide day-to-day care and give money including material support to their parents directly. Moreover, there has been a significant impact on the function of Thai rural families due to socioeconomic development (Pinyuchon and Gray 1997). The percentage of employed persons in agriculture has gradually dropped from 38.6 in 2008 to 37.7 and 37.1 in 2009 and 2010 respectively. Farm labourers move to towns to look for jobs (the National Statistical Office 2012). Knodel et al. (2010) studied the relationship between migrant adult children and rural parents in Thailand. They found that a large number of rural young people migrate to big cities for working because they thought that it was a chance to improve the quality of their family life.

Although the structure of Thai rural families has changed, the strong family bonds are no different. Adult children who live outside their parent's province always support them by sending money and/or material support such as clothing and goods to them. They use the telephone for remaining in close contact with their parents (Knodel and Chayovan 2009). It was shown that adult people continue to foster family relationships by looking after their parents and/or grandparents and teaching their children to follow the custom to be grateful to their parents whether they live together or not. These practices can be seen and are still relatively strong in Thai families especially in rural areas (Limanonda 1995).

In summary, it is significant that caring for ill people is undertaken by women in the family regarding Thai family life (Jongudomkarn and West 2004; Jullamate et al.

2006; Meesuk 2005; Prawtaku 2006). This implies that the most usual person to provide care to a stroke survivor is their spouse or a female. Failing this, it is provided by a close family member, parents, siblings or children. Apparently the idea of becoming a carer is symbolised and framed by the ordering of socially acceptable family organisation.

In Thailand, Buddhism forms a core part of the belief system and is a powerful influence on the national culture. The majority of Thai people are Buddhist and follow the Theravada or Hinayana forms of the religion. The teaching focus of Thai Theravada Buddhism is on the law of karma and the concept of reincarnation or the rebirth cycle. The meaning of karma in Thai Buddhism is the actions which involve the intention of acts, thoughts and speech. Every action produces the fruit of karma. One possible explanation is that the law of karma is the law of action and reaction, or 'cause and effect'. If an individual does 'good' he/she will be the recipient of 'good' as the fruit of good karma. In the same way, if the individual does 'bad', he/she will be the recipient of 'bad' as the result of bad karma. No one can escape from the power of karma. Good/bad karma in past lives can follow the individual and be carried over to his/her next life. Buddhist lay persons enhance good karma by merit making in order to reach the end of suffering or nirvana. There are various ways to make merit. The act of showing gratitude is counted as one way of making merit (see detail in section 2.3.3, Feeling rules). Although Buddhism forms a core part of the belief system among Thai Buddhists, there are wide variations in the way they hold spiritual beliefs and their degree of spirituality (Chamratrithirong et al. 2010; Craft 1999; Mokkhabalarama 1988; Pinyuchon and Gray 1997; Shaw 2006; Sivaraksa 2002).

The majority of Thai families are structured as the nuclear family (the National Statistic Office 2012). However, extended families are commonly found in rural areas. The rural family culture shows a patriarchal structure in which men hold the duty of family leader and generally work outside the home, while women mainly have responsibility for doing household chores and taking care of all family members. Furthermore, in Thai culture, parents and older people are considered as

holding the highest status in the family. Thai people have been taught since they were young to respect and show gratitude to their parents by looking after them when they get old or sick. Returning a 'good thing' to a benefactor is one of several ways to fulfil the gratitude system as dictated by the beliefs in Buddhist values. Gratitude is central to Thai people's minds as a necessary qualification for a 'good' person (Jullamate 2006; Prawtaku 2006; Sangngam 2006; Srivichit 2007; Vongvipanond 1994).

2.5 Conclusion

This thesis is drawn from the literature in the fields of stroke, emotion work and family relationships. A number of qualitative and quantitative studies draw out the importance of stroke survivors' and carers' emotional experiences during daily living activities at home. Many of these studies revealed psychological burdens following stroke among stroke survivors and carers related to their decreased quality of life and low well-being. While formerly employed as a nurse, I have personally experienced conversations with many stroke survivors and carers in communities, and found that sometimes their behaviour does not match their true emotions and they always suppress their emotions instead of presenting their feelings to other people. Little is known how their emotion management during care at home is related to its expression to each other, how they give meanings to care, and how they construct their thinking in routine daily life in order to maintain their relationships.

Emotion work in the family home is guided by social rules, cultural norms and family context in complex ways. It shapes human behaviour and produces lived experiences of emotions. Individuals need time, energy and effort to engage in emotion work. From this viewpoint, the concept of emotion work may enhance the understanding of stroke survivors' and carers' emotional experiences in daily lives and the way to improve their quality of life and emotional well-being. However, it is evident from the literature that there is a lack of research into emotion work and stroke care in the home environment.

The focus of interest for this thesis therefore is on the nature of emotion work during caring interactions between stroke survivors and their carers. The way in which they create their roles after the stroke event and their lived experiences relating to the management of emotions and feelings during daily routine activities, are also examined.

The next chapter describes methodological issues and an ethnomethodological approach for carrying out the study.

Chapter 3

Methodological Issues

3.1 Introduction

This chapter presents an account of the methodology employed to seek the answers to the questions proposed in this thesis. Findings from the literature review and reflective thinking about the purposes of the study inform the main research question:

What is the nature of emotion work during caring interactions between adult stroke survivors and carers?

In order to answer this question, it is necessary to present a reasoned trajectory for the study. Reflecting on philosophical underpinnings of research regarding the nature of the study is important for researchers to justify using particular methodologies and methods (Crotty 1998). The consideration of ontology and epistemology which underpin the current study is important to provide an explanation as to why those methodologies are suitable to capture stroke survivors' and carers' experience of engaging in emotion work and to answer the main research question.

This chapter is structured in the following way. Firstly, an overview of the basic philosophy (ontology and epistemology) which underlies this study is discussed, in order to clarify my approach to studying relevant social phenomena. Ontological and epistemological views associated with methodology and methods are addressed. Then, the rationale for adopting qualitative research and a discussion about a particular methodology for this study are illustrated. I present key concepts in ethnomethodology coined by Garfinkel (1967). For this interpretive research, an ethnomethodological approach and methods used for collecting and analysing data are also introduced

3.2 Ontological and epistemological underpinnings of research

Ontology, epistemology, methodology and methods are the key components of a research paradigm. Every research area has its own ontology, epistemology, and consequently its own methodology and methods due to the way of discovering knowledge through the conduct of any research approaches (Scotland 2012). In philosophical traditions of conducting research, ontology and epistemology are recognised as the fundamental considerations of research. Having and understanding knowledge of the research philosophy are important to underpin choices and decisions on a research position (Bryman 2012). This section discusses the philosophy underpinning social research including the role of the particular methodology and methods applied for my study.

Raadschelders (2011) compared ontology and epistemology with the horses which pull the carts (methodology and methods) for carrying out research. The consideration of ontology and epistemology is significant as the starting point of differentiating between quantitative and qualitative research approaches. Ontological and epistemological perspectives link to researchers' ideas behind the particular research design and the process of data analysis (Livesey 2006). It may be assumed that there are the connections between them. Ontology and epistemology become researchers' suppositions about the world and their awareness of focus of the study. These ideas are embedded in the way researchers set research questions they intend to study and govern and influence the use of methodology and methods.

In order to articulate the position of this study, providing assumptions about ontology and epistemology are necessary. Ontology is a theory involved in the nature of existence and social entities (Bryman 2012: 32). The assumption of ontology is concerned with what is considered as reality and how the reality is made up. Epistemology is a theory of knowledge and knowing. The assumption of epistemology is about the ways of what we can know about the world, how we conceive knowledge, what rational thoughts actually are and how knowledge can be created (Bryman 2012; Holloway and Wheeler 1996; Scotland 2012).

For ontology, which concerns beliefs about the nature of the world, two different stances which are frequently referred to are objectivism and constructionism. With respect to objectivism, the existence of social phenomena and their meanings is independent of human meaning-making, and it is separated from social actors. Conversely, constructionism holds the belief that social phenomena and their meanings are constantly constructed by human beings who are members of a social world (Bryman 2012). The consideration of the ontological position provides the philosophical questions as to what social phenomena are counted as reality and how those phenomena come into the state of existence (Bryman 2012; Major 2005; Raadschelders 2011; Scotland 2012). It appears that ontological orientation indicates the way researchers view the actual world. This view relates to the formulation of specific research questions.

From the ontological assumption described above, constructionism appears to suit the particular needs of my study which focuses on stroke survivors' and carers' views of routine activities of undertaking emotion work involved with social interactions in their everyday lives. An approach that posits constructionism is connected with social research (Bryman 2012). Individuals and groups cause social phenomena to have continued existence with shared meaning and with being a part of those societies or members of the culture (Bryman 2012; Cupchik 2001). Constructionists raise the idea of "multiple realities" (Parahoo 2006: 43) which indicate that human beings can have different perceptions within one reality. Moreover, constructionist research is associated with qualitative methods (Crotty 1998). These imply that the reality emerges from the notion of relationships between social constructions and social actors, and the same phenomenon can produce various meanings accomplished by any given actors in a given situation. This notion led me to understand the nature of the reality that I proposed to study. It is also a way of developing research questions about what constitutes the nature of stroke survivors' and carers' emotion work and how their emotion work is constructed in relation to everyday lives and surroundings.

With regard to epistemology, assumptions focus on beliefs of what we can know about the world through appropriate methods to do research. The consideration of the epistemological position contributes to the way of how we can know the world (Bryman 2012; Raadschelders 2011; Scotland 2012). This involves researchers' beliefs in dependable ways to create knowledge. Positivism and interpretivism are two main paradigms in social, health and nursing research that have contrasting beliefs in how phenomena should be studied and what constitutes scientific knowledge (Parahoo 2006: 45). Positivism holds a belief about an objective reality. Positivist epistemology is about what we can know through observable facts (Raadschelders 2011; Scotland 2012). Interpretivism holds different epistemological considerations. It gives attention to how human beings interpret and create subjective meanings of action in social reality (Bryman 2012). Parahoo (2006) stated that the foci of interpretivism are on subjective experience, perception and language to explain human behaviour. The choice of methods interpretivists use is interactive and flexible for collecting data from conversation and narratives, and the type of data analysed is not conducive to statistical approaches. Therefore, interpretivist epistemology provides researchers with the philosophical stance to approach multiple realities and to gain insight through the creation of knowledge by a comprehensive understanding of social phenomena. It also guides them to create the way in which they come to know about the existence of the world through human social actions based on how social actors construct and interpret their social world.

As my study lies within interpretivist epistemology, I am particularly interested in how I can know much more about stroke survivors and carers' ideas, feelings and emotions as part of the nature of their social world. I focus on the way of thinking and practical reasoning demonstrating how stroke survivors and carers create their roles and construct the meaning of feelings and emotions in a given situation, and the practical strategies which they use for managing their emotions during caring interactions caused by undertaking emotion work. Suitable methods of data collection in a constructionist paradigm are interviews and observations. The interview method may be used for recreating stroke survivors and carers' lived experience of how they engage in emotion work and how they reason about doing

that, and observational methods may be useful for capturing the existence of emotion work and for understanding the nature of the emotion work process in their own meanings. Moreover, interpretivist epistemology and constructionist ontology appear to be suitable for studying the existence of the world originating from the interactions between social actors and the contexts of phenomena.

3.3 Methodological perspectives

The philosophical underpinnings of this study provide a comprehensive understanding and explanation of human and social reality. In the ontological position, the nature of social phenomena is generally regarded as falling under constructionism which is the construction of social actors' perceived social reality. The umbrella of interpretivism which relates to the interpretation of the social world by social actors is located in the epistemological position. From the epistemological position, engaging in emotion work between stroke survivors and carers can be understood as the creation of symbolic gestures in connection with the management of one another's feelings resulting from the relationship between social interactions and their contexts (Hochschild 1983). In this way emotion work is identified as a dependent variable of social interactions in a given situation. In order to develop knowledge of emotion work among stroke survivors and carers in the family home, the important issue is how best to conduct research. I now discuss the methodological perspectives considered suitable to address the research questions and aims of the study.

At the beginning of considering a suitable research design, three research studies regarding my primary research interest which used various methodologies were explored. The first study investigated care of stroke survivors (Kratz 1978). This study focused on nursing in the community and the important role of district nurses in long-term care of stroke survivors. The problems of persons with stroke in the community were also illustrated, inspiring my research interest in the area of stroke survivors and carers in the family home. The second was Savage's study, nurse-patient interaction. This research took an ethnographic approach to explore how

nurses understand the notion of closeness and assessed the support they might need where close relationships with patients are encouraged (Savage 1995). This study provided the inspiration for thinking about the quality of caring interactions and closeness. For my study using an ethnomethodological approach, I took inspiration from the study by Lawler (1991). Here an ethnomethodological approach and grounded theory were combined to explore how nurses manage body care and what they take for granted caring for the body of others.

As discussed earlier, positivists' beliefs are rejected by interpretive social scientists who centre on social actors' experiences and dependent events. Qualitative research approaches are suitable to facilitate the exploration and understanding of human experience and social phenomena within research settings. With regard to the nature of the study and requirement of research questions, many kinds of qualitative methodologies were considered to be appropriate for exploring and understanding the nature of emotion work taken from stroke survivors' and carers' points of view. The methodologies which originate in anthropology, psychology and sociology are well known in qualitative nursing research (Polit and Beck 2008). In order to identify the best strategy for answering research questions, a comparison of different qualitative methodologies' characteristics has been drawn up in order to find the best methodology to suit the aims of my study. After considering many qualitative methodologies, three possible research designs, i.e. grounded theory, ethnography and ethnomethodology, meet the study objectives (Hammersley 2002; Marcon and Gopa 2008; Moule and Goodman 2009; Parahoo 2006; Polit and Beck 2008). A comparison of different characteristics of these three approaches to research design is summarised in Table 3.1.

Table 3.1 Characteristics of Grounded theory, Ethnography and Ethnomethodology

Dimension	Grounded theory	Ethnography	Ethnomethodology
The base	- Sociology	- Anthropology	- Sociology
Sample	- Individuals, groups	- Small groups	- Individuals, groups
Objectives	- Describe and understand phenomena of relevance to social psychological and structural processes in a social setting (why people act; what happens; what is going on) - Develop a theory of how individuals and groups in the area under study actually have effects on each other; of how particular concepts are grounded in reality	- Interpret and understand culture systems, cultural phenomena, people's beliefs, rules and norms - Explore hidden meanings, patterns and experience of members of a cultural group in their world views and everyday life	- Understand members' methods of how they produce recognisable social order - Explore individuals' daily life and social experience - Understand and uncover individuals' perception of what is normal or right to do related to culture, norms, and beliefs
Research questions	- What theory can explain social phenomena that occur in real world events and true life experiences?	- How do people define their position in a particular social context? - How do people in a cultural group interact with each other? - What kind of relationships are constructed in the cultural group?	- What is individuals' perspective on doing things in the routine everyday life? - How do individuals/groups conduct their behaviours to find social acceptance? - How do individuals/groups make sense in everyday life?

Three considerations are briefly described here so that I can better explain and clarify my justification for the selection of ethnomethodology. The first consideration is area of interest. Ethonomethodology and grounded theory focus on social settings and patterns of behaviour, whereas experiences of group culture are the concern of ethnography (Polit and Beck 2008). In this sense, all research approaches appear to be able to meet the focus of interest in this study because the study's attention is on

social actors' behaviour, social phenomena, culture, beliefs and its relationship to social structure.

Secondly, another point of considerable interest is the sample unit. Grounded theory centres on groups and individuals. Ethnomethodology focuses on individuals as members of a given society as well as social groups, whereas ethnography studies group cultures. The samples of this study include stroke survivors and carers who live together in their own home. For this reason, data would not be gathered as part of a group culture. Therefore, the methodological approaches of ethonomethodology and grounded theory are both possible for my study.

Finally, the main purpose of each methodological approach is an important consideration for this review. Ethnomethodology explores the methods that individuals use in their everyday activities in order to create a sense of order for further actions, and to understand how individuals make sense in order to behave in a socially acceptable way relating to social experience (Button 1991; Goodman and Strange 1997; Wilson 1989). The focus of grounded theory is to develop hypotheses and theories of how humans actually work together in their own environment involving social experience (Glaser and Strauss 1967). It reveals "the core variable that is central in explaining what is going on in that social scene" (Polit and Beck 2006: 53). Ethnography seeks to interpret and understand the cultural group lifestyle and tacit knowledge in the everyday life of a cultural group (Bryman 2012; Moule and Goodman 2009).

With regard to the three main considerations discussed above, ethnomethodology holds the best place for answering the research questions of my study. An ethnomethodological approach is concerned with how social actors use the underlying and taken-for-granted practices in their everyday lives. The approach can be applied to explore and understand how stroke survivors and carers make sense in order to perform and practically engage in emotion work within the context of caring interactions in the family home. According to Lawler's study (1991), the combination of ethnomethodology and grounded theory was to study the body and

social life managed by nurses in their own culture. Ethnomethodology was used for exploring nurses' 'taken-for-granted' knowledge of the body and the strategies that nurses used for dealing with embarrassment that they felt towards patients' bodies. It also provided a way of thinking about how people make sense of a particular situation and manage them in everyday lives.

The nature of my study is as follows: 1) it is a study of an individual's feeling and emotion which is a micro level of sociology used for exploring events at individual level rather than being focused on broader social phenomena, 2) it is about the details of feelings which are 'normal' routine in day-to-day life, 3) it is a way to access tacit feelings of individuals who may not always easily describe why they take action in a particular way, 4) it focuses on the 'taken for granted' practices and individuals' methods of gathering order through concrete evidence, 5) it is a study which involves aspects of intimacy between the survivors and carers, within Thai culture and the context of general customs and beliefs, 6) this approach elicits common truths from subjective views in everyday language.

3.4 Ethnomethodology

An ethnomethodological approach has been selected to describe and explore how stroke survivors and carers engage in emotion work during caring interactions in everyday practices. The term 'ethnomethodology' was coined by Garfinkel (1967). It is a branch of sociology that seeks to understand the production of social order and to explore how individuals interpret practical meanings of routine situations in everyday situated practices (Garfinkel 1967; Goodman and Strange 1997; Marcon and Gopal 2008; Peyrot 1982). Rawls stated that the definition of ethnomethodology is developed from three words, 'ethno', 'method' and 'ology':

> Ethno refers to members of a social or cultural group (or in Garfinkel's terms, members of a local social scene) and method refers to the things members routinely do to create and recreate the various recognizable social actions or social practices. Ology as in the word sociology implies the study of, or the logic of, these methods. Thus ethnomethodology means the study of members' methods for producing recognizable social orders (Rawls 2002: 6).

The concept of ethnomethodology emphasises the authenticity of local social orders and situated practices. The interactions between social actors construct knowledge which is embedded in the context of everyday situated practices (Srinivasan 2007).

The theoretical background that underpins ethnomethodology belongs to a group of theories which are underpinned by interpretivism (Marcon and Gopal 2008). This is as regards the methods used for discovering knowledge and how to know the world which may guide the way of data collection adopted due to the clarification of practical research aims. There are three main approaches to interpretivism, including "Weber's notion of Verstehen, the hermeneutic-phenomenological tradition and symbolic interactionism" (Bryman 2012: 30). Ethnomethodology is close to interpretive approaches because it pays attention to the subjective side of social organisation and social actors' points of view (Marcon and Gopal 2008). For example, Denzin (1969) stated that a synthesis of ethnomethodology and symbolic interactionism emphasises how individuals perform in society and in which ways they make sense and interpret meanings through symbolic connections to social interaction (see also Moule and Goodman 2009). These perspectives focus on micro-sociological approaches and provide a view of social organisation and the process of social interaction in nature. The similarity of both perspectives is "a link between the person and social structure" (Denzin 1969: 922). It implies that ethnomethodology and symbolic interactionism are positioned in the same class which centres on the individuals and subjective views of practical social arrangements.

Ethnomethodology is drawn from many sources of inspiration. Garfinkel's thoughts were influenced by Ludwig Wittgenstein (the ordinary language philosophy) and C. Wright Mills (the theory of account) (Rawls 2002: 2). Wittgenstein's and Mills's works provided the theory of meaning and of social order for the study of social practice (David 2009; Rawls 2002). Talcott Parsons's Structural Functionalism is another source of Garfinkel's inspiration. In 1954, Garfinkel's graduate work in sociology was under the direction of Parsons at Harvard University. His Ph.D. dissertation, *The Perception of the Other: A Study of Social Order*, (Rawls 2002: 4) appeared to be a reaction against Parsons's idea which focuses on the basis of social

order as the outcome of value and norm consensus in any given society, and social actors' behaviour as internalised and constrained through socialisation (Maynard and Kardash 2006). It can be seen that Parsons's concept of social action and order places emphasis on the motivation of action by internalised values and norms in society as an external standard of following scientific rational procedures, and the concept pays little attention to the management of social actors' concrete actions in real time as in Garfinkel's concept. Bowers (1992) argued that Parsons's concept led Garfinkel to emphasise the issues of social order in actual conduct and of common-sense knowledge and practical reasoning employed by social actors and expressed through their point of view.

Garfinkel's ideas were also deeply influenced by humanistic and phenomenological traditions (Goodman and Strange 1997), especially by the phenomenological writings of Alfred Schutz (Zimmerman 1978). Phenomenology and ethnomethodology have their main interest in the shared experience of social members (Keel 2001). However, phenomenology which originates from psychology and philosophy focuses on individual lived experience (Polit and Beck 2008), whereas ethnomethodology focuses on how members of society make sense and understand the rules of interaction "on the basis of tacit knowledge" (Holloway and Wheeler 1996: 153). Ethnomethodology has its own theoretical underpinning which is informed by phenomenology. Although an ethnomethodological approach resembles phenomenological sociology, its focus is the existence of the 'real' world in the way that people create a sense of order and reasoning constructed through conversation, behaviour and other gestures (Garfinkel 1967). A researcher does not begin a project with presumptions in mind. Rather, the researcher begins with an area of study and enters a real situation seeing it for the first time (Button 1991). Garfinkel acknowledged having the inspiration for a distinctive perspective of ethnomethodology from the writings of "Talcott Parsons, Alfred Schutz, Aron Gurwitsch and Edmund Husserl" (Garfinkel 1967: ix).

Garfinkel (1967) developed the ethnomethodological perspective as an alternative way of doing sociological analysis and investigation. Garfinkel's classic book

Studies in Ethnomethodology was published in 1967. The concept of ethnomethodology is defined:

> Ethnomethodological studies analyze everyday activities as members' methods...Their study is directed to the tasks of learning how members' actual, ordinary activities consist of methods to make practical actions, practical circumstances, common sense knowledge of social structure, and practical sociological reasoning analyzeable; and of discovering the formal properties of commonplace, practical common sense actions, "from within" actual settings, as ongoing accomplishment of those settings...Ethnomethodological studies are not directed to formulating or arguing correctives. They are useless when they are done as ironies. Although they are directed to the preparation of manuals on sociological methods, these are in no way supplements to "standard" procedure, but are distinct of them. They do not formulate a remedy for practical action, as if it was being found about practical action that they were better or worse than they are usually cracked up to be. Nor are they in search of humanistic arguments, nor do they engage in or encourage permissive discussions of theory (Garfinkel 1967: vii-viii).

From the provocative excerpt above, ethnomethodological studies focus on the social fact which is internal to individuals. Individuals are seen as social actors of a given social organisation in that they make the production of practical reasoning to make sense of their everyday activities in society. It is also a way of analysing social members' methods to achieve and display the understanding of their everyday world and social entity. In this sense, ethnomethodology is able to be oriented in both micro and macro sociological approaches. The social members can create the social face and produce everyday meaning of how a given society works at either the micro (individuals) or macro (organisations) level. For this study, I centre on the personal structure of how stroke survivors and carers make sense of everyday meaning in their social world as a micro-sociological approach. Furthermore, the way they interact with each other during care tasks allows me to see the practical reasoning based on their background and normative expectations in a given situation in order to explore the nature of engaging in their emotion work.

There are two key concepts associated with ethnomethodology, namely indexicality and reflexivity. The term indexicality means that individual words and ideas draw on contexts and surrounding circumstances for aspects of their meaning in use in

relation to the normative expectation (Garfinkel 1967; Koschmann et al. 2004). Goodman and Strange (1997) present an example of what indexicality is:

> To understand anything we have to know the context within which they are spoken. The phrase "how are you?" means one thing when a friend asks at a casual meeting, and another when a general practitioner asks at a surgery. This is because the context of a chance encounter with a friend differs from that of meeting a professional for a consultation. If you remove the context from around the words, their precise meaning is lost (Goodman and Strange 1997: 143).

It appears that making sense of the meaning of words is predicated on the context that the words are used. Indexicality provides insights into the goal of social phenomena and the accomplishment of social actors' behaviour as an in situ process of practical reasoning including a sense of reconsidering retroactive words.

Reflexivity is the thinking process for undertaking social action through which individuals understand the real world in a practical way for making sensible decisions. The individuals construct their idea of understanding by using knowledge they have already accumulated and at the same time their explanatory accounts are stimulated by similar situations they deal with which are influential in confirming or developing accounts (Garfinkel 1967; Goodman and Strange 1997). The documentary method of interpretation furnished by Mannheim interests Garfinkel that social actors use to reach a consensus on accepted fact and pattern of social structure. Garfinkel asserted:

> The method consists of treating an actual appearance as "the document of," as "pointing to," as "standing on behalf of" a presupposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of "what is known" about the underlying pattern. Each is used to elaborate the other (Garfinkel 1967: 78).

It appears that reflexivity of accounts is the process of how social actors explain a specific social situation and make sense of it. Relying on reflexivity of accounts, ethnomethodologists are interested in the (re)construction of the accounts and the

methods employed by social members (Keel 2001; Marcon and Gopal 2008). This conveys ethnomethodology and sociological research as a broad challenge.

3.5 Using an ethnomethodological approach

According to the ethnomethodological perspective, it governs a choice of method in the practical studies as regards a network of philosophical ideas. Maynard and Clayman (1991) presented the diversity of ethnomethodology and found that there are a wide range of research studies in this field. Marcon and Gopal (2008) illustrated the diversity of ethnomethodology compiled from a number of scholars' works as shown in Figure 3.1.

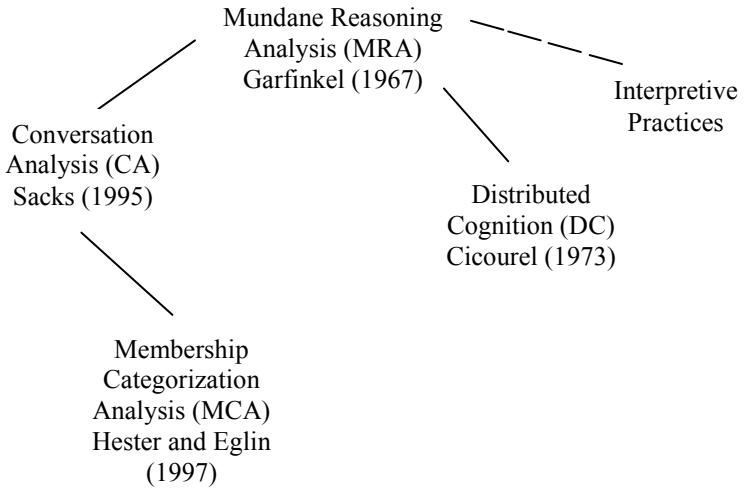


Figure 3.1 The diversity of ethnomethodology (Marcon and Gopal 2008: 167)

Marcon and Gopal (2008) argued that ethnomethodology is critical because there are various branches in which it has been adapted. Ethnomethodological branches include the work of Cicourel in 1973, the role of cognition in social life (Maynard and Clayman 1991) and conversation analysis developed by Sacks in 1995 which seeks to explore the language patterns of social interaction (Moule and Goodman 2009). Membership categorization analysis pioneered by Hester and Eglin in 1997 is placed as a hierarchical branch of conversation analysis. Interpretive practices have a loose connection with the fundamental concept of ethnomethodology (Heritage 1984;

Marcon and Gopal 2008). It appears that those approaches come from the same intellectual tradition and centre on similar aspects of social actors' everyday lives in social worlds. This thesis focuses on the production of ordinary social activities in connection with the nature of stroke survivors' and carers' emotion work during their caring interactions in the home environment. This thesis then takes place within the area of mundane reasoning analysis illustrated by the work of Garfinkel (1967).

As discussed earlier, Garfinkel is interested in the process of social actors' sense-making and reflexive accountability in everyday practice. A study of jury deliberation provided him with the fundamental ideas of common-sense knowledge and methods that a jury used in organised ways which occur in a jury room. Moreover, Garfinkel's breaching experiments designed to violate everyday rules or to make problems in ordinary social life as a way to study them are well known (Maynard and Clayman 1991). These experiments lead to insights into the individual level which produces the rules of social interaction in particular situations. It also reveals the ideas of taken-for-granted orderliness of everyday life (Rawls 2002). For example, in the experiment on a game of tic-tac-toe, Garfinkel found that common-sense practices are employed and made visible by performing in a way that is consistent with previous knowledge about rules of the game. The experiments that are troublesome events of disrupting ordinary practices and social norms appear to be a way to understand social order (Garfinkel 1967; Maynard and Kardash 2006). Those studies provide useful perspectives on the 'taken-for-granted' rules and the practical methods that social actors used to deal with a problematic situation in ordinary social life. This thesis will concentrate on what stroke survivors and carers know about achieving emotion work during caring interactions and on what they take for granted.

A study of Agnes (Garfinkel 1967) shifts the focus of interest from the breaching experiments for examining common-sense practices to a more extended consideration of disruption to everyday life (Rawls 2002). In Garfinkel's study, Agnes was extensively interviewed and observed many times throughout the trajectory of male-to-female transsexual (involving undergoing a transsexual

operation). For Agnes, being a woman is problematic for the accomplishment of her everyday activities. Agnes provided Garfinkel with telling experience of making herself visible as an ordinary woman. She also made up references to (false) female experiences in order to talk like a woman (Bowers 1992). Garfinkel represented Agnes as a practical methodologist that is using "members' methods for producing correct decisions about normal sexuality in ordinary activities" (Garfinkel 1967: 180). Garfinkel compared a game metaphor with Agnes's passing occasions as a transsexual. Unlike a game which has a time-out and in which a player can stop playing, coming across as a natural woman requires a continuation of manifesting femininity in any social interaction. The work of Agnes's sexual passing as a female person illustrates how she produced and reproduced a state of affairs instead of asserting it in a given interaction of everyday life (Bowers 1992; Maynard and Kardash 2006). It can be seen that the study illustrates the particular social issues and interpersonal strategies which Agnes actively used for managing herself as a real woman in the social world. Furthermore, the process of what she did about a feminine look is compatible with the majority of social actors' acceptance. The notion derived from the study of Agnes is that it would be possible to explore the practical methods of engaging in emotion work and the intrinsic values which stroke survivors and carers employ its tacit means in order to secure and guarantee the rights and obligations to display their feelings as practical activities through common-sense reasoning.

Although ethnomethodology is a study of social members' practical methods for producing social order, there is no specific method itself. For ethnomethodologists, the various methods have been used to conduct their research. Breaching experiments are always mistaken as a specific methodology of ethnomethodology. In order to discover the methods social members use; the practical reasoning process they have and the orderliness of social order patterning, the methods with regard to the retrospective accounts of social order are unable to be used for those ethnomethodological aims. This issue reminds the researcher that the suitable methods have to gain detailed knowledge of local order production (Garfinkel 1967; Maynard and Kardash 2006; Polit and Beck 2008; Rawls 2002).

The major focus of data collection for the work of ethnomethodology is on social everyday realities. Interviews and observation are applied in ethnomethodological studies. For example, Smith and Gray (2001) studied emotional labour in student nurse education. Their study was carried out through an ethnomethodological approach, and data were collected by interviews. Interviewing is a way of gathering social members' knowledge production of the social world through talking about their lives (Holstein and Gubrim 2002; Topping 2010). Holstein and Gubrim (1995) pioneered the notion of the active interview mainly influenced by ethnomethodology (Garfinkel 1967) and other related approaches. They described the active interview as "reality-constructing" and "meaning-making occasions" (Holstein and Gubrim 1995: 4). In their opinion, all interviews are the active interview. The active interview is seen as a reflexive approach which makes visible the interpretational and reflexive process of participants (Fernqvist 2010). In this sense, the interview method is chosen for this thesis because of not only collecting empirical data about the view of rational production as a potential source of participants' lived experience, but also data about their emotional expression during conversational interactions can be collected. The purpose of the interview is to understand the sense-making accomplishment of stroke survivors' and carers' emotion work and how the meanings are constructed.

Observation is another method selected for gathering data in my study. It is a research tool for studying human behaviour in the empirical reality. Conducting observation includes using the senses of sight, hearing, touch, smell and taste (Parahoo 2006). The observational method is used for indentifying reality-constructing activities and the pattern of practical social interactions in social worlds (Miller 1997). Observational methods are used by ethnomethodologists to explore how social actors deal with the contingencies in a given situation (Baszanger and Dodier 1997). Apparently observations used in ethnomethodological studies centre on taken-for-granted and unnoticed practices. For this thesis, observations are used for seeking to describe interactional activities between stroke survivors and carers that produce the process of emotion work and whether their emotional expression including gestures are compatible with a particular situation. Therefore, combining

two data collection methods (interview and observation) provides rich data and detailed information about common-sense knowledge and reasoning in stroke survivors and carers in relation to engaging in emotion work.

For data analysis, there are many ways to analyse ethnomethodological work (Garfinkel 1967; Heritage 1984). Ethnomethodology has no particular procedure for data analysis. The core analytical process is through an analysis of the indexicality and reflexivity of accounts (Keel 2001). Ethnomethodological analysis of interviews focuses attention on the interactional event during the conversational process of questioning and answering between interviewer and interviewee (Baker 2001a). Using interviews is also beneficial to ethnomethodological studies for recreating lived experience (Morse and Field 1996). Miller stated that "the methods of special interest to ethnomethodologists are the various interpretive procedures that we routinely use to classify aspects of our experience and to establish connection between them" (Miller 1997: 28). There are four aspects of ethnomethodological analysis. The first aspect is the reality-creating activities which include the cultural categories: social members, behaviour and contexts. Concern with indexical assumption and reflexive accountability are the second and third aspects. Finally, social circumstances always are changed (Miller 1997). The notions of indexicality and reflexivity appear to be the core of ethnomethodological analysis.

3.6 Summary

In this chapter, the detailed accounts of philosophical traditions, methodological considerations, an ethnomethodological approach, the use of data collection methods and the approach to data analysis taken for this thesis were discussed. Constructionist ontology and interpretivist epistemology underpin the study of stroke survivors' and carers' emotion work because it relates to social interaction and a meaningful construction of the 'real' social world. The ontological and epistemological traditions are philosophically compatible with the choice of possible research methodologies which are best suited to conduct my thesis.

A comparison of three qualitative research approaches, i.e. grounded theory, ethnography and ethnomethodology was drawn for clarification of why ethnomethodology was ideally suited to my study. The related issues of an ethnomethodological perspective were also described. Because ethnomethodology is a study of social actors' common-sense knowledge in everyday lives, for my study, an ethnomethodological approach was chosen for answering research questions about how stroke survivors and carers make sense of achieving emotion work during caring interactions; what methods they used for managing their feelings and emotions and for producing emotional expression in a given situation; how they created their roles following the stroke event; what the practical reasoning was and how those ideas were constructed.

An ethnomethodological approach allowed me to concentrate on the way stroke survivors and carers actively manage their lives in a given situation relating to emotional issues. Interviews and observations were research methods used for exploring stroke survivors' and carers' worlds in the empirical reality in order to understand and be able to explain their practical reasoning process of engaging in emotion work. The process of data collection was concerned with social actors' common-sense knowledge and members' methods. Although ethnomethodology does not have a specific process of data analysis, the way of analysing an ethnomethodological study is concerned with the assumption of indexicality and reflexive accountability.

The following chapter will detail the practical aspects of the study such as data collection, data analysis, translation and ethical issues.

Chapter 4

Study Methods: Conducting the Study

4.1 Introduction

The aim of this chapter is to explain how the study was carried out in order to explore the nature of emotion work during caring interactions between stroke survivors and carers. This study is based on an ethnomethodological approach which underpins the specific research design as discussed in Chapter 3. The main focus of this study is on the understanding of everyday reality in stroke survivors' and carers' social world as it takes place in their own home environment, with particular reference to the process of engaging in emotion work.

The structure of this chapter is as follows. Firstly, overarching aspects of data collection are given before I introduce the characteristics of research participants, setting, timing and methods. Secondly, validity and reliability of the study are discussed. Thirdly, I consider the issues of doing fieldwork and the position of the researcher. Following on from this a description of the processes of data analysis and the way in which research findings are organised are presented. Then, the transcription of conversations and the translation of Thai into English are illustrated. Finally, ethical issues and the process of gaining ethical permission are described.

4.2 Data collection

Data collection is one of the most important processes in any research study. The effectiveness of data collection directly influences what researchers can know and identification of knowledge in the study (Ackroyd and Hughes 1981). This section describes in detail the activities of how data were gathered. Locations, the study samples, methods and the process of data collection are given.

4.2.1 Locations

According to the original plan for selecting research participants, it was proposed that twelve pairs of participants would be drawn from the rural communities of Nakhon Sawan Province located in the central region of Thailand. Nakhon Sawan Province consists of 15 districts: Muang Nakhon Sawan, Banphot-Phisai, Chum-Saeng, Chum-Ta-Bong, Kao-Liao, Krok-Phra, Lat-Yao, Mae-Poen, Mae-Wong, Nong-Bua, Phaisali, Phayuha-Khiri, Tak-Fa, Takhli, Tha-Tako. I intended to recruit one or two pairs from each district in order to achieve a sample of participants from across the Province. The possible way to discover the discharge locations of stroke survivors over the entire Province was to access to the Sawanpracharak hospital's database. This is because there is one community hospital in each district, and the information and referral system of community hospitals is linked to the main hospital in Nakhon Sawan Province (Sawanpracharak hospital).

The plan for accessing the research locations had to be changed because of the effect of the flooding crisis in Thailand. My fieldwork began in October 2011 and finished in January 2012. At the time of the study there was significant damage throughout most of the anticipated locations. As a result of damage to roads caused by the severe floods, I made a pragmatic decision to focus on 2 of 15 districts in Nakhon Sawan Province closest to my home town. Those districts suffered less serious effects of flooding, and the access roads through the areas were not closed. It was possible and safe to drive there. The data collection process therefore was conducted in Krok-Phra district (9 pairs) and Lat-Yao district (3 pairs).

4.2.2 Sample and recruitment

Purposive sampling was chosen to access participants who were best-placed to answer the goals of the study. The sample was selected from subjects deemed eligible for recruitment who fitted a particular profile and had had experience of a stroke either as a survivor or a carer. The research participants consisted of twelve pairs of stroke survivors and their carers.

Inclusion criteria for stroke survivors were as follows:

(a) voluntary participation,
(b) aged between 18-59 years old,
(c) diagnosed with stroke and discharged from hospital at least 6 months after the onset of stroke with associated impairments or disabilities,
(d) continuing to live at home with moderate or severe disability,
(e) registered on the modified Rankin Scale for stroke disability (mRS) from 3 to 5 (see also pages 15, 23-24),
(f) conscious,
(g) able to give consent for themselves, and
(h) able to communicate in the Thai language.

The exclusion criterion for stroke survivors was exhibiting cognitive disorder and/or severe mental and psychological problems (clinical judgement).

Inclusion criteria for carers were as follows:

(a) voluntary participation,
(b) aged 18 years old or older,
(c) have acted as a main carer for at least 6 months,
(d) living with a stroke survivor at home,
(e) able to consent for themselves, and
(f) able to communicate in Thai language.

The exclusion criteria for carers were receiving money for looking after stroke survivors, and carers who were under medical treatment for mental and/or psychological problems. The exclusion criterion for a pair (stroke survivor and carer) was that one party did not want to participate in the study.

According to Sawanpracharak hospital's database, there were 49 stroke survivors who were under the age of 60, lived in Krok-Phra district, and were discharged from hospital with disabilities. From this database, 40 stroke survivors were excluded (14 survivors had a mRS score <2, 6 had communication difficulties, 3 died before

recruitment, and I was unable to visit 17 survivors because of damaged roads). Nine survivors from Krok-Phra district met the inclusion criteria. Only 5 stroke survivors from Lat-Yao district were visited due to limited road access. Two survivors were excluded because one decided not to participate in the study and another had communication difficulties. Stroke survivors who fulfilled all of the criteria were included in the study sample after requesting their permission. Following on from this the informal carers who took care of these stroke survivors and who met the inclusion criteria were invited to be involved in the study and subsequently recruited.

4.2.3 Methods

Two main methods were used for collecting data (semi-structured interviews and observation). First, semi-structured interviews are methods for understanding the detailed experience of participants (May 1991), and can be used effectively in the social sciences (Broom 2005) for "social explanation and arguments" (Mason 2002: 65). Furthermore, semi-structured interviews provide opportunities for making more inquiries and have flexibility to explore a range of situations and depth of information (May 1991). Researchers make further use of open-ended questions to assist them in obtaining an in-depth impression of the participants by observing non-verbal communication such as gesture, facial expressions, tone of voice and eye contact (Price 2002).

In my study, the focus of the interviews was on how participants made sense of their everyday reality and experience in the management of emotions during caring activities. These interviews aimed to explore the nature of stroke survivors' and carers' emotion work and to construct theoretical ideas around emotion work's values regarding this group. The content of the interviews consisted of an introduction, objectives, processes and a conclusion. I clarified every aspect by introducing myself, gave some information about purposes, method of the study, the process before, during and after interviews, the rights of participants, the interview period and permission to record the conversation. Each question had only one main idea in order to reduce confusion. Price (2002) suggested a laddered question

technique of using probe questions in interviews through the sequence of questions from less invasive to more invasive (action questions, knowledge questions and philosophy questions: feelings, values and beliefs) which enhances researchers' awareness of ethical concerns for making inquiries sensitively. From this, the process of each interview was set from broader to specific questions and from general to sensitive inquiries. Interview topic guides for this study were created from the aims of the study in order to answer the research questions (see Appendix 1).

The questions changed during an optimum period of interview depending on what topics needed exploration and how the participant reacted to a question at the time. Prompts can be used to ensure key points or topics are covered (Gillham 2000). In my study prompts were used for helping participants to talk in connection with the research questions. A hint was given to jog participants' memory. Probes were utilised for obtaining in-depth information in the conversation. Those probes were shown by questions, taking note, paying attention and using body language such as silence and eye contact (Rubin and Rubin 1995). For example, I said, "Please explain more about…" so that the participants could express more information on the matter. I used silence to give participants a bit more time to think about their story. I rephrased participants' statements in order to check understanding. Using signposts such as "turning to…" and "the next question…" were very necessary for signalling to the participants a change to other topics.

Second, one of the key methods in sociological research is unstructured observation. The foci of using unstructured observation are on what people act, what they say and how they interact with others in particular situations. The process of people's performance of activities and the whole picture of situations are also illustrated by unstructured observation (Mulhall 2003). I attempted to use unstructured observation instead of participant observation for collecting data in this study for three reasons. Firstly, unstructured observation was conducted in participants' natural environments (Moule and Goodman 2009). This led me to be able to observe a spectrum of participants' activities in their local circumstances without pre-conceived ideas, which was compatible with the concept of an ethnomethodological approach.

Secondly, the study was conducted in participants' homes and private areas. It was difficult to participate in their caring activities because of the limitation of the data collection period. In order to observe the behaviour of members and to elicit information on their behaviour within the context of participants' activities researchers may immerse themselves in a social setting or with families for a long period (Bryman 2012; Polit and Beck 2006). For example, Beck (2002) studied mothering of twins during the first year of life. She used ten months of fieldwork for regular staying and helping them to look after their children for sustained observation. The third reason was the introduction of my status. I introduced myself as a researcher. I did not allow myself to take part if there was a sensitive situation taking place between the participants which involved their grief and anger in order to reduce the risk of being ethically compromised.

Observation was based on participants' behaviours regarding how stroke survivors and carers expressed their emotions to each other during caring interactions. Although, I use unstructured observation, I involved myself in the scene of the caring interactions in order to be close to participants, to see their emotional expression and to hear what they said and how they said it. Sometimes, they talked to me, and I also responded. However, I did not interrupt their activity in any way.

I used demographic data forms to collect personal information. For stroke survivors, the form included age, gender, marital status, educational levels, duration of having a stroke and duration of home-based care. The demographic data on carers included age, gender, marital status, educational levels, duration of undertaking a stroke carer role, family income and occupation. These data were collected before the interview.

4.3 Trustworthiness

Trustworthiness acts as a validity and reliability check in order to reduce bias and ensure rigour in qualitative research. Credibility, transferability, dependability and confirmability are alternatives to validity and reliability in quantitative research (Lincoln and Guba 1985). Triangulation and member checks helped to establish the

credibility of my qualitative data (Bryman 2012; Olsen 2004; Polit and Beck 2006). Data source triangulation relates to using two sources of data from interviewing stroke survivors and carers about the same topic. Method triangulation could also enhance credibility in my study as I used two methods, i.e. semi-structured interviews and observation for data collection. I also undertook member checks as follows. The main points from interviews and observations were summarised at the end of each visit and during the last visit as a whole in order to make sure that I understood their narratives correctly and to enhance ethical considerations in connection with sensitive issues (Turner and Coen 2008).

In qualitative research, the researchers are research instruments for collecting data and carrying out data analysis (Moule and Goodman 2009; Polit and Beck 2006). Reflexivity should be the best method for reducing researcher biases. Reflective thinking enhances researchers' ability to check themselves and its findings (Pillow 2003). The use of reflexivity can also improve dependability and confirmability in qualitative research (Houghton et al. 2013). Reflexivity is discussed in more detail in Section 4.4 (Doing fieldwork). Moreover, I collected data allowing thick descriptions (Geertz 1973) which concerns details of a culture for assisting transferability (Bryman 2012; Polit and Beck 2006). The provision of detailed descriptions, appropriate data and accounts of the context are essential for enhancing transferability as readers can consider whether the findings are able to be used in another context (Houghton et al. 2013; Lincoln and Guba 1985).

The data collection process is illustrated in order to show how I set out to gather rich data and avoid bias in the data set. Overall there were 24 participants in 12 pairs comprising 12 adult stroke survivors and 12 carers. I visited each participant a minimum of 3 times. In the first visit, I approached the participants by accompanying a home-health care team to offer an introduction and request involvement in the study, explain the study, answer participants' questions and seek participants' permission to continue. I gave the participants a minimum of 24 hours to decide whether to take part in the study. I telephoned them or visited them in person for getting their answer.

After receiving the participants' permission, date and time of interviews were set by each participant. The semi-structured interviews were conducted for both stroke survivors and carers in the second step of the data collection process. Each participant would be visited and interviewed 2-3 times. I spent 1-3 hours in each visit for interview and observation. Interviews were on average 38 minutes. Minimum time was 12 minutes, and maximum time was 1 hour and 12 minutes. The 12-minute interview was a third-time interview and with a stroke survivor who needed to rest. Digital audio recording was used after asking permission and obtaining consent. Within each pair, participants were interviewed separately as I investigated the nature of the relationship and other special bonds between stroke survivors and carers. I wished to discover both specific details in each pair to gain a deeper view of experience and various aspects of all pairs to generate new knowledge and concepts regarding emotion work between stroke survivors and carers. The interview questions were focused on the different aspects of stroke survivors and carers in reflecting the emotions regarding their experiences of day-to-day living at home. The rest of the time I used for observation and chatting to their family members and neighbours.

The researcher needs to ensure that the surroundings and site of the interview are comfortable since an uncomfortable place might affect the quality of the data (Price 2002). The circumstances in which the interviews take place can influence interviewee moods and behaviour. A private room, far away from noise and disturbance are considered ideal. Researchers should give participants any information about the research topic to permit them to choose a place so that they will feel free to talk. If the interviewees cannot make a decision which place to suggest, the researcher may create possible alternatives (Elwood and Martin 2000). However, places should be safe and accessible not only for the interviewee, but also for the interviewer. In my data collection process, I asked participants about the location for the interview. The talks took place in many locations, e.g. a living room, a dining room, a public garden and a rice field. However, I phoned them on the morning of the appointment to confirm the place and time.

The last visit was used for member checking. I met each participant individually and talked about the whole contents of his/her stories and what information was gathered from observations. I also brought an interview report to them, to check if they agreed. This visit confirmed that I did not misunderstand what participants said and act erroneously on it. It was beneficial to gather additional information in order to clarify the data I had.

In each visit, field notes were taken as soon as possible after leaving the participants' houses. I also wrote analytical memos during initial data collection. This enabled me to maintain clarity throughout the interview process. It was useful for preparing follow-up questions and looking for themes, ideas and concepts to address research purposes. This is to avoid missing necessary points that researchers need to explore in-depth, and provide insights on the most important part of research concerns (Rubin and Rubin 1995). It is shown that early thinking about points and ideas in analysing data during fieldwork can enhance understanding of what is going on in the research process (Birks et al. 2008). An example of my analytical memos is shown in Appendix 2.

4.4 Doing fieldwork

Fieldwork involves practical activities which contribute to the research process of collecting data. It is carried out within real world conditions (Heimer and Thøgersen 2006; Srivastava 2004). Coping and learning are included in the activity of obtaining both tacit and explicit knowledge through the data collection process (Sether 2006). A learning process and personal development may be gained from the experience of doing fieldwork.

Over a period of three months I viewed my fieldwork as a journey towards a greater understanding of both the significant aspects of research purposes and personalised field learning. With the former, participants gave me their narratives regarding feeling as well as thinking about their world. On account of this I followed the theoretical foundations of fieldwork methodology which involved critical thinking

and adaptation of coping strategies. Regarding the latter, the experience of many narratives offers a window into how I managed my role and feelings to deal with difficult situations. It seemed to me that tacit knowledge or invisible learning could bridge the gap between the actual reality in the field and the process of changing behaviour to suit the situation. Friendliness, receptiveness and positive thinking were used to manage my role and feelings.

4.4.1 The position of the researcher in fieldwork

During fieldwork my role was reminiscent of my past role as a nurse. As a result of my nurse identity I was concerned with how I might impact on participant perception. Thai people especially in rural areas have great respect for health officers. If I introduced myself as a nurse, they might merely provide me with information of a medical aspect and/or hide some stories of routine activities in their everyday lives related to health. In practice, I decided to introduce myself as a PhD student who is studying in The University of Edinburgh, and interested in the areas of life after stroke and emotion work among stroke survivors and carers in order to avoid any bias in the storytelling of participants.

The following field note illustrates the result of my position as a researcher and how much the participants admired the officer. This is advantageous as it ensures unbiased opinions from participants. However the disadvantage here is gaining their trust. As a result of taking the training programmes in qualitative data collection I was able to overcome this through showing my profound respect for participants and their privacy. Furthermore, being a local person facilitated gaining participants trust:

> Karun (stroke survivor, pair 5) behaved differently from first visit where a health officer came along. He was very polite to the officer…He was reluctant to talk openly about his stories and the experience of healthcare service in detail. He seemed particularly worried about telling stories in connection with healthcare system and health providers. Although he used to get upset about unpleasant experience with some healthcare services, he did not complain about that in front of the health officer. He appears to try to avoid conflict and maintained harmony with health officers (Field note, 11/11/11).

A challenge for researchers is where to place the self as both an inner and outer part of research. According to the inside, the researcher is a research instrument (Patton 2002). Drawing on this view, the researcher must be prepared to adopt expert roles for collecting and organising effective data. According to the outside, the background of researchers and their position is considered within the research process (Malterud 2001). From this view, the process of developing knowledge in qualitative research locates the researchers as a part of the data where they co-construct and understand research seeking unbiased practices through reflective thinking skills.

As described earlier, I had the previous experience of dealing with people in the community as a healthcare provider. In addition, I used to be a main carer for my grandfather who had a stroke for two years when I was aged twenty-nine, and that meant I was also an insider in relation to experience of the subject-matter of this study. The experience of both aspects might cause preconceptions. Therefore, the important thing was to distance my own self and my own experience from the participants' experience in order to enhance rigour of this study. The following section discusses how I used the concept of reflexivity in qualitative research to place myself within the research.

4.4.2 Using reflexivity

Reflexivity is undoubtedly crucial to qualitative research because it is important to control a researcher's bias (Jootun et al. 2009; Pillow 2003; Sultana 2007). There are two principal types consisting of personal reflexivity and epistemological reflexivity. The former is influenced by the aims to sustain the ability of researchers to make decisions based on facts and evidence. This includes one's own values, experiences, beliefs, acquaintances, interests and commitments which influence the research (Dowling 2006). It allows researchers to develop self-awareness (Wolfe 2003). The latter refers to a broader view of reflexivity which enables researchers to reflect on the foundation of knowledge and the implication of findings relating to the study (Dowling 2006). This means that researchers can use reflexivity throughout the

research process for examining self-representation and self-determination. This is a way of researchers being accountable within the research process.

I used reflexivity as the process of reflection on myself throughout the conduct of my qualitative research study. Reinharz (1997) stated that there are many aspects of the researcher's self in qualitative research. The different selves of a researcher within any research situation can influence the researcher's thought and behaviour. I used reflexivity for reflecting my different selves while undertaking qualitative research. I explore the reflective process through Mesa (carer, pair 4), for example. Mesa had suffered from an emotional burden. Samart (her husband, stroke survivor) frustrated her as she was not able to persuade him to exercise. She said that she was getting bored of telling him the same thing every day but he ignored her. She tried various methods to encourage him to do regular exercise (pretending to be angry at him, assisting in leg and hand exercises, explaining reasons and friendly talk). This disheartened her, and she informed me that she did not give much attention to her husband's exercises anymore:

> Mesa (Shaking her head) I don't know what I can do. I am at my wit's end with this problem. I used to say both good and bad ways, but he didn't do. He responded by silencing. I have no idea what to do.
> Maturada So far he hasn't taken any exercise. Is that right?
> Mesa (Nodding and sighing) (line 44-45).
>
> Reflexive memo: Her tone of voice, gestures and body language were clear and presented that she still worried about his health and was willing to help with rehabilitation. She struggled to deal with this problem and needed someone to help her find a solution. Within 15 seconds of her interview, she talked to me twice about what way to solve this problem.

The last sentence of the memo is about the severity of her feeling on this problem. I realised that I wanted to help her to find ways of solving problems. This concerned me and I considered my role as a researcher. At the same time the variety of the selves I bring to this field was created. I felt powerless as I could not act as a nurse within the field. Despite this difficulty I maintained my role as researcher and carried on with my fieldwork. Post interview I asked for her permission to refer this problem to a health officer who has responsibilities to deal with such problems. She allowed

me to do this and gave me a big thank you. As a local person I knew well about their culture. It was possible to talk and behave properly during this interview and fieldwork.

4.4.3 Emotions of the researcher in fieldwork

Because this study focuses on emotion work among stroke survivors and carers, it is clear that this study addresses a sensitive area for all people who are involved in it including me as a researcher. Every human being has their own emotions, and it concerned me greatly that participants risked their emotions and feelings during and after interview. Working in a sensitive research area also has an influence on the researcher's emotions (Dickson-Swift et al. 2009; Nicholson 2009). It was necessary to put arrangements in place to prevent causing emotional harm to both participants and the researcher.

Risk assessments can be used by researchers to minimise the emotional impact on participants, and many researchers have reported dealing with emotional issues when undertaking qualitative research (Bondi 2005; deMarrais and Tisdale 2002; Dickson-Swift et al. 2008; Hubbard et al. 2001). Emotional experiences, of course, happened to me during fieldwork. I then think critically about emotional risks to researchers in research practice. This section focuses on the intensity of the feelings rather than the amount of them, and how I confronted my emotional burdens by using/practising the conscious method or sa-ti (Thai language).

I experienced a strong emotional response when deciphering the way I expressed my emotions recorded in the early field notes:

> I began to think about a matter of feeling 'fear' while driving to first participant's home although the field was familiar to me. I felt very nervous before the start of the first interview. I was faced with extreme stress and anxiety because a sensitive topic such as this could make an unpleasant situation worse. The participant warm welcome reassured me and reduced my anxiety. It was a good beginning and made me feel less worried. I reflected on this and decided that I should not worry in advance as this puts unwarranted pressure on me. During this interview I pretended to be calm in front of the

> participant although I felt uncomfortable and dissatisfied with the result…I still felt unhappy and want to leave there (Field note, 30/10/11).

From the emotional experience during this fieldwork I felt very tired when I got home. As the field note illustrates, this initial approach was not conducive to obtaining a successful interview. I realised that the successful interview should lead to a sense of achievement (generating rich data and feeling comfortable for both an interviewer and an interviewee). I therefore had reflected on what happened with my feelings and why these feelings occurred. I found that I had been losing control of my emotions during the interview. The control of emotions from the inner mind needed to be adjusted. From this point, I learnt to think positively and accepted the challenge of research with enthusiasm including how to control my feelings.

A peaceful mind is the way of managing and expressing my emotions. I decided to start practising meditation as the Buddhist way to enhance sa-ti. In Buddhist texts, sa-ti is defined "as an interconnected phenomenon" (Christopher et al. 2009: 594). It supports efforts to keep calm and relaxed including self-control by reducing the beginning of an emotion or thought (Deleanu 2010). Many scholars reported that mindfulness practice or sa-ti can decrease emotional problems such as stress (Chu 2010; Mohan et al. 2011), anxiety (Coppola and Spector 2009), and depression (Disayavanish and Disayavanish 2007). Spirituality and religious beliefs influence Thai people's minds (Choowattanapakorn et al. 2004; Lundberg and Thrakul 2012). As a Thai Buddhist, I have been taught how to deal successfully with a difficult situation by following Buddhist ethical principles and practising meditation since I was young (in school, in public institutions, etc.). Therefore, I was familiar with meditation. Moreover, I successfully used sa-ti for solving my problems, and I believed that meditation producing sa-ti brought great benefits to the structure of my mind during dealing with difficult emotions in fieldwork.

Sa-ti is self-control that arises from a sense of self-awareness. My emotions and feelings can be controlled easily resulting from meditation training. For example, I used sa-ti to manage and express my emotions when I was faced with a sad story. Firstly, I listened intently to what Nisa (stroke survivor, pair 7) said. At the same

time, I developed an awareness of what I felt and what I thought about her story. Secondly, I tried to identify my feeling. In this situation, I felt a lot of sympathy for her. The third step is the management of my personal feeling. I took a few deep breaths to stop this feeling, including pulling myself back when I realised the feeling of sympathy. It was the way in which I could explicitly consider my feeling and ensure the appropriate role was established. By this method I could regulate and express my feelings to reduce biases.

In summary, I have explored my experience of fieldwork as a researcher. Self-awareness and self-control arose from the processes of interpersonal interactions and intrapersonal learning skills. I can say that meditation and praying are the most appropriate methods for inducing a peaceful period before going into the field. I did deep breathing before, during and after interviews in order to decrease stress and anxiety. I can use sa-ti at every moment for balancing my emotions in fieldwork even in my everyday activities. Sa-ti and reflexivity were practical methods used for enhancing reliability of my study and maintaining my emotional well-being. Although the two methods tended to overlap, they helped me maintain the researcher's role, and manage and express my emotions in an appropriate way.

4.5 Data analysis

One of the most commonly used methods for qualitative analysis of interview transcripts is thematic analysis. Thematic analysis can be found throughout qualitative research, including ethnomethodological studies. For example, Robertson et al. (2009) applied ethnomethodological study and thematic analysis to generate and to construct the core values of Australian psychiatrists. From this study thematic analysis was helpful in establishing a theoretical model. Montbriand's study (2004) explored the trajectories of illness, and data were analysed by theme which presented participants' taken-for-granted perceptions of illness and healing. It demonstrates that thematic analysis can be used for analysing data in an ethnomethodological study.

A thematic approach to analysis does not "require pre-determined codes that are imposed upon the data, but tends to take the data at face value or literally" (Dew 2006: 79). Benner (1994) argued that thematic analysis allows reflection on the meanings of individuals' everyday life which consists of understanding, interpretation and investigation of what appears across cases. Inductive reasoning was used for generation and interpretation of data into particular themes. The procedure for thematic analysis was to read each participant's interview, and to identify prominent themes (Watson et al. 2008; Wilson 1989). In my study, data were analysed by themes demonstrating key meanings and prominent patterns in participants' thoughts on their relationship set in the context of cultural practices.

4.5.1 Primary concerns

When writing my research proposal I considered how raw data were analysed in an appropriate way. Polit and Beck (2010) suggest that this is useful for synthesis of ideas about research purpose and methodology. Methodological background and research questions were considered when developing my study. The methodological approach chosen is ethnomethodology which enables the researcher to gain insights into routines of interaction that people use in social life and what the rationales they give for activities of social order influenced by culture. Two key concepts, reflexivity of accounts and indexicality, are specific to ethnomethodology (Garfinkel 1967; Moule and Goodman 2009; Robson 2002).

Reflexivity and indexicality are the heart of data analysis. The notion of reflexivity is "philosophical self-reflection or a kind of introspection" (Marcon and Gopa 2008: 169). Indexicality refers to how an individual gives meaning to a given situation in relation to his/her experience and its context (Garfinkel 1967; Koschmann et al. 2004). In this study, an ethnomethodological approach was applied for discovering what practical methods stroke survivors and carers used for managing their feelings and emotions in everyday lives and how their accounts are constructed.

4.5.2 Preparing transcripts

Post data collection audio-recorded interviews were transcribed. The accuracy of transcription is very important, and researchers need to make sure that there are no margins for error (Polit and Beck 2006, 2010). Deliberate alterations of the data, accidental alterations of the data and unavoidable alterations (facial expressions, body language, etc.) that cannot be captured by audio recording are three major groups of errors during transcribing verbal data into texts (Poland 1995; Polit and Beck 2010). The first two groups of errors can be prevented by using reflexivity, concentration and ethical concerns during the transcription period (Pagis 2009). Taking field notes and making observations can minimise the problems of unavoidable alterations. The processes of triangulation, for which I used two main methods (interviews and observation) including taking field notes for checking results and using member checks led to reducing errors or misunderstandings which might occur in fieldwork (Bryman 2012; Olsen 2004). This means that the accuracy of verbatim transcription has an important influence on data analysis, and researchers can prevent these errors through other methods supporting strategic transcription and research designs.

Halcomb and Davidson (2006) argued that verbatim transcription of interview data may be unnecessary if there is not a particular closeness between researchers and the verbal interview data. However, I needed word-for-word transcription although audio-recordings were consulted when I needed to clarify what the participant said, an exact tone of voice, rhythm and anything else relating to his/her current emotion. Field notes were useful to recall the circumstances of interview. These methods ensured closeness with the data.

4.5.3 Using computing software versus using manual methods

Thai script was maintained during the process of data analysis. It was risky to translate whole interviews from Thai into English because it might lose meaning. Some specific words in Thai (Ya-Moh, karma, etc.) were difficult to define in

English during the analytic process. Moreover, it was necessary to remain in Thai script because the ethnomethodological approach focuses on what meaning people generate in their language and what methods they use for making sense of the world relating to circumstances and culture (Garfinkel 1967). Regarding the development of themes in qualitative research by manual operations and by using computer software, each of them has different advantages and disadvantages. It is evident that the process of thinking, judgment and interpretation of qualitative data come from researchers, no matter what methods are chosen (Coffey and Atkinson 1996; Kelle 1995; Wolcott 1994). Therefore, the decision about the appropriate way of how to analyse data depends on what the chosen method can support and be compatible with researchers.

There are five advantages in undertaking a mechanical process using computing software for analysing data. First, large amounts of data are stored on a single location, and the coding scheme is handled by using the click of a mouse button (Bergin 2011). Second, it provides easy access to multimedia data and makes links to external sources as additional in a part of data. Third, the location of codes and particular annotations on sections of data can be searched quickly within the content of particular nodes (Welsh 2002). Fourth, it can illustrate the process of accurate and transparent data analysis for improving the consistency of approach among team research and for theory-building (Weitzman 2000). Fifth, data descriptions are displayed with graphical depictions of the analytical structure developed. It is useful for exploring and presenting data in various ways (Wiltshier 2011).

Disadvantages include the difficulty of gaining a deeper understanding of data because of mechanical processes relating to the content of particular nodes and distancing researchers from the data (Bergin 2011; Welsh 2002); lack of the closeness of the transcription symbols (Baker 2001a; Cameron 2001). It may be less useful for other kinds of analysis in social science research studies because it is based on thematic analysis and grounded theory (Hutchison et al. 2010; Welsh 2002). Moreover, the software is an expensive one, and it takes time for the new user to become skilled and experienced in using, e.g. NVivo.

In order to achieve the best results, I chose a manual method for analysing data. The reason was that the study relies on an ethnomethodological approach. It was necessary for being close to the script for affording insight into the meaning behind the texts. Some symbols in the script were not able to be coded by the software. Moreover, the manual method enhances familiarity with the data (Welsh 2002). Regarding my personal reasons, using a computer assisted method involved too many mouse clicks. It was not able to show many pages at one time. The letters in the working area of NVivo were too small. I was really quite uncomfortable when working with this software. I preferred working on paper to working on computer screen. However, the knowledge of coding and creating patterns from NVivo can be applied to manual techniques.

4.5.4 Analytical route

Thematic analysis is applied for identifying, analysing, and interpreting patterns from data rather than capturing content (Ryan and Bernard 2003). Thematic analysis was suitable for my study for three reasons. Firstly, many different qualitative techniques including thematic analysis could be applied to ethnomethodological studies because there are no fixed methodological approaches to collecting and analysing data (Robertson et al. 2009). Secondly, thematic analysis is commonly used for analysis with interview methods and requires insightful data which was compatible with an ethnomethodological approach. I collected data myself and this ensured that I was familiar with these data (Braun and Clarke 2006; Kabay 2006). Thirdly, unlike some other analytical methods such as discourse analysis, conversation analysis and grounded theory which are dependent on specialised theory, thematic analysis is not theoretically bounded and is fairly flexible in that it can be applied to a wide range of theoretical approaches (Braun and Clarke 2006).

A literature review informed the thematic analysis approach (Braun and Clarke 2006; Wilson 1989). Nine practical steps were applied. Firstly, research questions and methodological background were discussed in section 4.5.1 (Primary concerns). Secondly, the texts were divided into two groups (stroke survivors' and carers' data).

I kept the texts separate at the beginning to enable identification of interesting points in each group of people and individual details, roles and situations (Polit and Beck 2010). I did this in order to distinguish the findings of the stroke survivors' experience of emotion management from the carers'. However, data from field notes and from observation on shared experience between them were also analysed for exploring their emotion work when they interacted with each other in daily life.

Thirdly, the decision about using a manual method for analysing data as discussed earlier led to the next step which was to understand real meanings of the texts and circumstances. I read carefully through each Thai script without taking notes. At the same time, considering the circumstances was an additional way for gaining understanding of the meaning of the words. I thought that an intense concentration on the script was very necessary although employing this method produced a very time-consuming stage. Notwithstanding, I decided to carry on with this method because I wanted to pay more attention to the texts; my concentration was not interrupted by taking notes; the real meanings of each word was explored to make this clear.

The fifth step involved re-reading and taking notes. I read each script again to make sure that I properly understood it. When I finished a script, I thought about what information I obtained from it, what the feelings of the participant during interviewing were, why he/she felt like that, and how he/she constructed his/her ideas and feelings. Moreover, I analysed how I made sense of what the participants felt when I was reading the script and when I was at fieldwork. This ensured adequate reflection which enabled me to gain a sense of their feelings. I then took notes of the important points. I did not take information from the script when writing my notes as I wanted to use my own words to describe the topics for categorisation purposes.

Coding texts into categories is the sixth step. After examining the raw data to gain an understanding of the meanings of words embedded in the texts, categories were identified with separate coding schemes. Descriptive, topic and analytical coding are three sorts of coding used in qualitative research. Analytical coding was applied

because I had to understand the intended meaning of words and sentences before I decided to put them into a specific group (Lyn 2005; Lyn and Morse 2007). During allocating words or sentences into a group, writing memos is very important to state ideas about each time those words or sentences are coded (Lyn 2005). Forty-three and forty individual codes from the stroke survivors' and carers' data from the texts respectively were retrieved into separate groups. It is true that coding cannot be finished in one 'go' through the texts because of too much information, and it is a time-consuming task. It took me at least two times to code each script, ensuring that each reference was arranged for a correct code.

I then reduced separate codes to categories by finding connections between each of them. Sixteen and fifteen categories of data from stroke survivors and carers respectively were refined for grouping into patterned units of meaning. The description of categories is shown in Appendix 3. Searching for initial themes is the seventh step. It focuses on the broader level of themes and sorting the different codes into potential themes (Braun and Clarke 2006). I used mind-maps to allocate codes and/or categories to themes which enabled a visual representation of relational coding (i.e. cause, property, aspect, associate, result and contrast) for generating primary themes.

I re-read all extracts and considered coherence between categories and subthemes. Ten subthemes were defined as a result of this step. There were four subthemes emerging from stroke survivors' accounts of their belief (stroke survivors' experiences of the first six months post stroke, stroke survivors' reasoning with themselves about the cause of their stroke, stroke survivors' attitude towards themselves and stroke survivors' attitude towards carers). Three subthemes (becoming a main carer, carers' attitude towards stroke survivors' health and the influence of neighbours) came from carers' accounting for their care of stroke survivors. The situations with caring interactions between stroke survivors and carers from observational data and interviews led to three subthemes (emotion work as part of daily life, emotion work as reflection and gender differences).

The next step is definitions. Each major theme was given a name that "identified the essence of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures" (Braun and Clarke 2006: 92). Themes were then represented diagrammatically to explain the findings as a whole. The extracts of categories, subthemes and themes on stroke survivors' and carers' emotion work are shown in Figure 4.1. Writing up the report is the final step. The report of findings is about a summary of main issues, describing extracts, evidence for the theme and literature relating to themes investigated (Braun and Clarke 2006; Jones et al. 2011).

The data analysis consisted of two phases. Thematic analysis based mainly on the interview data took place in the first phase as discussed above. The second phase of analysis involved the series of basic themes, the observational data, the re-reading of field notes and analytic memos. The common-sense methods they used for making sense of emotional experiences were the main focus of data analysis in the second phase. This phase established the connection between the various aspects of the nature of stroke survivors' and carers' emotion work which became the conceptual framework (the process of emotion work).

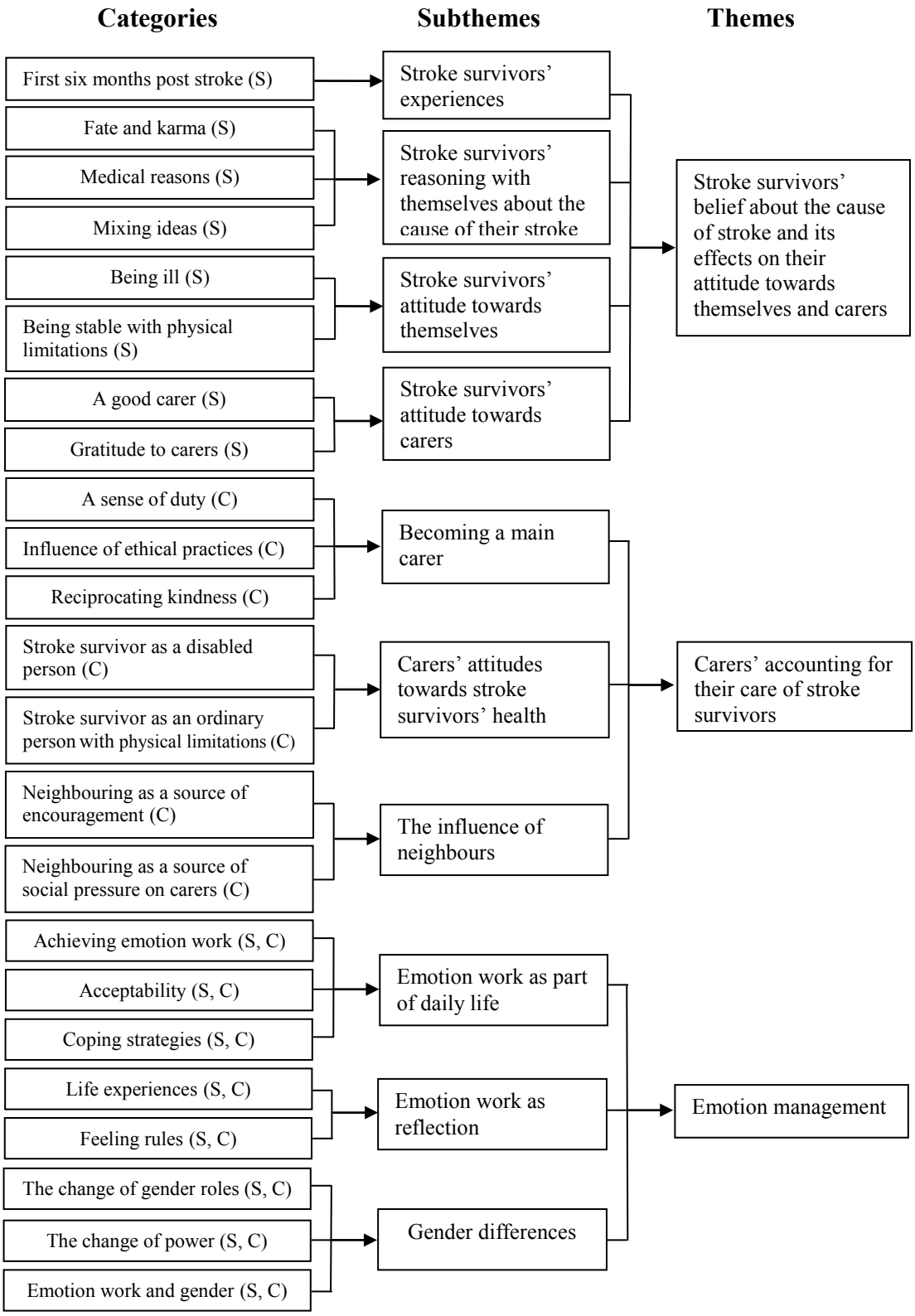


Figure 4.1 Extracts of categories, subthemes and themes on stroke survivors' and carers' emotion work

S = Stroke survivors' data; C = Carers' data

4.5.5 Translation issues

Back-translation is commonly recommended for semantic equivalence which concerns the preservation of underlying meaning of the source language (Polit and Beck 2008). In my study, I applied the procedure of translation and back-translation developed by Chen and Boore (2009). This procedure was established from a review of the literature on translation procedures in qualitative research, and they found that the procedure was able to reduce any discrepancies between the original source language and a target language and increase trustworthiness in qualitative nursing studies.

There are four steps for the process of translation. The first step is a transcription of the conversations discussed in the section on preparing transcripts. The process of data analysis was conducted in the Thai version. The second step is a translation of scripts which occurred in the period of writing up the study report. In this step, excerpts (interview data) which related mainly to themes were translated from Thai into English. Seeking appropriate translators was important for the following steps. Polit and Beck (2008) suggested that original texts should be translated by people who speak the target's native tongue, and back-translation should be carried out by people who are the original source's native tongue. In my study, selected translators were familiar with both cultures. One was a native English speaker who used to live in Thailand as an English teacher for more than five years and now lives in England with a Thai wife. Another one was a native Thai speaker who was fluent in English and has lived in Scotland for fourteen years. Some excerpts were selected by the researcher for translation. These texts were translated from Thai into English by the researcher and a bilingual person who was a native English speaker. The third step is a final English version with full agreement between the two translators. The last step is back-translation. I asked another bilingual person who was a native Thai speaker for back-translation of themes in Thai.

4.6 Ethical considerations

Two main questions are of concern while doing research into human beings: "What is right or good? and what should I do?" (Wilson 1989: 66). Ethical principles which lead to the rights of study participants should be considered prior to developing research questions and during reviewing literature (Moule and Goodman 2009). According to three basic ideas of the Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research (the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979), beneficence is a research responsibility to emphasise minimization of harm and maximisation of benefits. Respect for persons is the act which includes description of the fact and the nature of the study to participants for their information. The participants also have the right to decide not to participate in the study, including withdrawing at any time during its course. Justice refers to ensuring that every participant is treated fairly and equally, as well as participants' rights to keep their personal secrets (see also Polit and Beck 2006: 87-91).

Considerations of ethical issues have been a primary concern since the initial stage of research processes because ethical risks might arise at any time during carrying out the study. Ethical considerations are beneficial to prepare researchers for dealing with ethical issues in practical ways. My study was approved by the School Research Ethics Committee, School of Health in Social Science, The University of Edinburgh before the start of the data collection process. For conducting research in Thailand, I followed local guidelines for working with vulnerable participants and sensitive topics including gaining approval by The Sawanpracharak Hospital Research Ethics Committee for access to the hospital's database in order to retrieve stroke survivors' prognosis after hospitalisation and their discharge locations. I also obtained permission from Nakhon Sawan Provincial Public Health for collecting data in the rural areas of Nakhon Sawan Province. A summary of the research proposal, a participant information sheet and an informed consent form in a Thai-language version including the research proposal in an English-language version were needed to apply for ethical consideration in Thailand. Participant information sheets and

informed consent forms in Thai and English versions are given in Appendices 4, 5, 6 and 7 respectively.

It is inevitable that possible distress might arise from researching sensitive issues with vulnerable people. For example, three different levels of sensitivity when researching juvenile prostitution are "the socio-political, the ethical-legal and the emotional" (Melrose 2002: 336). Researchers must concern themselves with these sensitivities and protect the safety of participants. Ethical principles and guidelines are needed to reduce emotional harm during carrying out social science research, especially in an interview situation involving emotive issues (Shaw 2011). Protecting participants' privacy and confidentiality, providing detailed information to participants about the research and the researchers' background, preventing possible harm to participants and enhancing equality in potential power imbalances between researcher and participant are important in interview research (Allmark et al. 2009). My study is conducted on both a sensitive issue (the illness experience and emotional experiences) and with vulnerable groups (stroke survivors and carers). Therefore, ethical considerations were involved at a variety of stages in this study due to a possibility of psychological harm or stress for vulnerable participants.

In the participant selection stage, the sample selection was subjects who were best-placed for meeting the aim of the research. People had a right to decide whether or not to take part in the study. Information about discharge locations and discharge status of stroke survivors in Nakhon Sawan Province was accessed after receiving approval from the Sawanpracharak Hospital Research Ethics Committee.

In the data collection stage, I accompanied a community nurse to be introduced and for building trust. The community nurses did not know what participants were interviewed about. The community leaders did not know who participants were. I only informed the community leaders that I am doing research for a PhD thesis in the community as a matter of courtesy. I introduced myself as a PhD student who is studying in The University of Edinburgh and interested in the area of emotion work in daily life rather than as a nurse in order to avoid any bias of participants.

I gave details of the study to participants, i.e. interview, observation, permitting them to ask questions, explaining about risks and benefits of the study, maintaining anonymity, signing the informed consent document and asking them for permission to audio record, all without deception. I gave them a participant information sheet and the researcher's telephone number and e-mail address for asking questions at any time. I allowed a minimum of 24 hours between first contact and agreement to enter the study and sign an informed consent form. After the informed consent was signed, I asked each participant to choose a place and time so that he/she would feel free to talk. If the participant could not make a decision which place to suggest, I would create possible alternatives.

I interviewed participants separately for private conversation, and checked permission for digital audio recording. I emphasised that the participant could withdraw at any time. During interviewing, I would not pressurise the participant. If a participant felt worried, uncomfortable and/or nervous, I would stop interviewing and recording immediately, would then allow a participant to decide whether to continue without asking reasons, and would refer to a psychiatric specialist or a community nurse with their permission if participants needed or if necessary for protecting them from psychological harm. The main points from interview and observation were summarised at the end of each visit. In the last visit, I presented a summary of transcriptions and observations to each participant for clarification of his/her own narratives. All participants agreed. I offered copies of the summaries to participants but no one wanted one.

When I left each participant I confirmed that both raw data and electronic files would be kept anonymously, personal information about each participant such as name, address and telephone number would not be given in the report. Digital recordings, transcriptions and memory sticks or USB sticks would be stored in a locked cabinet placed in a secure room until they were destroyed. Raw data and electronic files would be preserved for ten years after each participant had signed an authorisation. Protecting against data loss or theft would be secured by authorised users' identification, password protection, antivirus controls, firewall configuration and

automatic backups. Raw data and electronic files would be locked in a filing cabinet and will be stored in a secure room. Restricted users would be identified by password protection.

In the data analysis stage, decreasing the researcher's bias and ensuring translation from Thai into English correctly would be addressed by using a translation and back-translation procedure. A co-translator would be used for the back-translation method but only for those quotations and summaries of the data that would be repeated in this thesis and publications. Participants' names were changed to preserve anonymity.

Reflexivity in fieldwork would be used for reducing the researcher's bias. A reflexive researcher remains aware of ethical considerations and sensitive issues throughout the research (Etherington 2007; Guillemin and Gillam 2004). Because of having experiences in the community for many years, I had to remind myself not to ignore other points of view during fieldwork and analysis. I had to remain vigilant regarding ethical practice at every step of the research process, and decide how to respond appropriately to what the participant said or performed during the interview.

4.7 Summary

This chapter illustrates a detailed account of the practical methods for conducting this study. The process of data collection, validity and reliability, doing fieldwork, the data analysis process and ethical considerations were discussed through the nature of an ethnomethodological approach. The critical enquiries of this study would have the potential to widen the understanding of personal situated perspectives on routine activities and explorations of caring interactions between stroke survivors and their carers, through studying the underlying structure of common-sense situations in everyday lives.

This thesis focuses on stroke survivors' and carers' emotion work during caring interactions in their home environment, how their accounts in connection with

emotion work were constructed and how they created their roles after the stroke event. A sample of 12 pairs (12 stroke survivors and 12 carers) was recruited. Nine pairs lived in Krok-Phra district, and 3 pairs lived in Lat-Yao district, Nakhon Sawan Province, Thailand. Data were gathered in the community at the participants' houses or a nearby preferred location. Semi-structured interviews and unstructured observations were the main methods of collecting data. Individual face-to-face interviews were undertaken with participants at least twice, an average of 38 minutes a time. Each unstructured observation lasted a minimum of 60 minutes.

Trustworthiness of the study was improved by using triangulation, member checks and researcher's reflexivity. Data were analysed using a manual method instead of using computer software. Interviews were audio-recorded and transcribed verbatim. A thematic analysis approach was used for drawing out the main themes that emphasised how stroke survivors and carers made sense of undertaking emotion work. The study commenced after receiving permission from the School Research Ethics Committee, School of Health in Social Science, The University of Edinburgh. In Thailand, ethical issues were approved by the Sawanpracharak Hospital Research Ethics Committee and permission to collect data in the areas of Nakhon Sawan Province was given by Nakhon Sawan Provincial Public Health.

The following chapter introduces the characteristics of all participants presented in pairs. Stroke survivors' and carers' experiences of using traditional and modern treatments/medication including religious beliefs for curing a stroke will be discussed.

Chapter 5

Participants' Background

5.1 Introduction

This chapter provides the detailed background and context of twenty-four study participants or twelve stroke survivor-carer pairs. When stroke survivors and carers faced changes in their life situation resulting from a stroke, their knowledge base and everyday experiences of dealing with difficult situations were put into practice to enable them to continue living. The focus on micro level analysis of stroke survivors and carers in the family home provides an understanding of how they created a caring context in their everyday lives.

This chapter comprises two sections, and is structured in the following way. The first section illustrates detailed information about the study participants. An overview of twelve stroke survivors' and twelve carers' personal profiles is shown in Table 5.1 and 5.2 respectively. Following this, the participants' family backgrounds and how they have adapted their lives to stroke are presented in pairs. In each pair, a description of relationships between stroke survivors and carers is provided. The story of each participating pair and the quality of relationship between them was developed from field notes, observation and interview data.

The second section presents background information on participants' attitudes towards medicines and treatments to cure stroke. This section points out the sense stroke survivors and carers made of their search for a cure, how they decided on those curing methods, and what methods were of importance to them. The ways of thinking about a cure for stroke demonstrate stroke survivors' and carers' use of their common-sense knowledge, lived experience and practical reasoning to make a decision. It is related to their personal cultural beliefs and is a matter of everyday routine living.

5.2 Detailed information about the participants' background

This section on participants' background presents the trajectory of a stroke event and living conditions for the participants in connection with emotional issues and social life. In order to protect participants' anonymity, the names of all participants are pseudonyms, and each stroke survivor-carer pair is numbered from one to twelve.

5.2.1 Demographic Information

I begin with an overview of the characteristics of the twelve stroke survivors and twelve carers. All participants were Thai living in rural areas of Nakhon Sawan Province, Thailand. All were Buddhist. The background characteristics of the participants enhance the understanding of personal circumstances in their everyday living. The following demographic data illustrate the preliminary findings and summarise detailed information for the groups.

The characteristics of stroke survivors are presented in Table 5.1. Of the twelve stroke survivor participants, 7 were male and 5 were female. They ranged in age between twenty-five and fifty-nine years old. Among these, seven stroke survivors were in their fifties. Most stroke survivors had primary school education (9). Two stroke survivors had attended secondary school, and one had the High Vocational Certificate[2]. Three-quarters of all survivors were married. Three stroke survivors were separated (1 female, 2 males), and two of them separated from their spouse after having the stroke (1 female, 1 male). All survivors were right-handed. Half of the survivors had right-sided weakness of their upper and lower extremities. The time from the onset of stroke was a minimum of nine months, and the maximum was ten years. The length of stay in hospital was between a week and two months. Only one stroke survivor was not hospitalised after the acute phase of stroke. All stroke survivors had significant dependence on carers, as measured by the modified Rankin Scale (mRs). They had moderate disability (mRs of 3) after having moderately severe disability (mRs of 4) during two months to one year from the stroke onset.

[2] A qualification you gain on completing a further education course at vocational school

Table 5.2 presents informal carers' characteristics and their relationship to stroke survivors. Eight of twelve carers were female. They were between twenty-seven and seventy years of age. Ten carers were married. The marital status of the rest was single and separated. Regarding educational achievement, the majority of carers had completed primary school (11). Only one carer completed a Bachelor's degree. Family incomes were from 10,000 to 40,000 baht per month. In comparison with the average monthly income per household in Thailand (20,903 baht) and the average monthly expenditure per Thai household (16,819 baht) (the National Statistical Office 2009), there were nine families reporting a family income less than the average monthly income per household. Eight of them earned 15,000 baht per month or less. The main occupation was farming (10). Seven of twelve carers had two jobs, as farmers and labourers, and five of these had a family income less than the average monthly income per Thai household. The duration of being main carers was between nine months and ten years. All carers had started taking care of stroke survivors since the beginning of the stroke event. The relationship between carers and stroke survivors varied. The majority of carers were spouses (8) and the rest were blood relatives including two mothers, a son and an older sister.

Table 5.1 Summary: characteristics of stroke survivors

Pair	Name	Gender	Age (yrs)	Level of education	Marital status	Period of having stroke/of hospital admission	Weakened part	The mRs	
								mRs of 4	mRs of 3
1	Somsri	female	56	Primary school	married	9 yrs/none	right	4 mo	now
2	Pichai	male	50	Primary school	married	10 yrs/1 mo	right	1 yr	now
3	Prasit	male	38	Primary school	married	3 yrs/2 wks	left	2 mo	now
4	Samart	male	57	Primary school	married	9 mo/1 wk	left	8 mo	now
5	Karun	male	44	Secondary school	married	10 mo/2 wks	left	3 mo	now
6	Umpa	female	25	Secondary school	separated	2 yrs/2 mo	right	2 mo	now
7	Nisa	female	52	Primary school	married	2 yrs/1 wk	left	1 yr	now
8	Duangjai	female	59	Primary school	married	5 yrs/1 mo	right	1 yr	now
9	Sumet	male	54	Primary school	married	2 yrs/1 wk	right	4 mo	now
10	Kamol	male	39	Primary school	separated	3 yrs/1 wk	right	5 mo	now
11	Prasom	male	47	High Vocational Certificate	separated	1.5 yrs/1 mo	left	6 mo	now
12	Mena	female	57	Primary school	married	6 yrs/1 wk	left	4 mo	now

Table 5.2 Summary: characteristics of carers

Pair	Name	Gender	Age (yrs)	Level of education	Marital status	Family income (baht/mo)	occupation	Length of being a carer	Relationship with a survivor
1	Somchat	male	51	Primary school	married	10,000	Farmer, labourer	9 yrs	spouse
2	Supa	female	44	Primary school	married	12,500	Farmer, labourer	10 yrs	spouse
3	Somsong	female	36	Primary school	married	25,000	Farmer, labourer	3 yrs	spouse
4	Mesa	female	42	Primary school	married	10,000	Farmer, labourer	9 mo	spouse
5	Pranee	female	60	Primary school	married	15,000	Farmer	10 mo	spouse
6	Naree	female	50	Primary school	married	10,000	Farmer, labourer	2 yrs	mother
7	Prakit	male	60	Primary school	married	10,000	labourer	2 yrs	spouse
8	Pracha	male	27	Bachelor's degree	single	40,000	self-employed	5 yrs	son
9	Wipa	female	55	Primary school	married	10,000	House-cleaner	2 yrs	spouse
10	Usa	female	53	Primary school	separated	20,000	Farmer, labourer	3 yrs	older sister
11	Somjai	female	70	Primary school	married	15,000	Farmer	1.5 yrs	mother
12	Thawon	male	58	Primary school	married	30,000	Farmer, labourer	6 yrs	spouse

5.2.2 Family backgrounds

This section presents a description of participants' lives, work, character, etc. The main focus of ethnomethodology is on social actors' common-sense knowledge and methods used for encountering typical occurrences and everyday situations (Garfinkel 1967; Sharrock and Anderson 1986). For this, it is necessary to have information on participants' lived experience in order to bring meaning and to identify current experience and manifestations of their concern. This description of participants' background aims to portray the practical understanding underpinning participants' everyday experience. The description is presented as a scene in the world of their daily lives regarding the stroke event and emotional issues. The scenes presented captured the nature of participants' experience as understood from my own vantage point.

Each participant's background was derived from a series of interviews, observation, field notes and visual information, i.e. photographs and videos which provided data visualisation and image processing for recalling the details of domestic circumstances and events during the observational and interviewing periods. A more detailed description of participants is intentionally withheld to safeguard anonymity.

Pair 1: Somsri (wife-stroke survivor) and Somchat (husband-carer)

Somsri (56) and Somchat (51) had been married for twenty-seven years. They had a son (25) and a daughter (17). Their son was married and lived at his wife's house located in the same village, and he often visited his parents at least once a week. Their daughter who was currently studying in grade 12 lived with them. Their main occupation was rice farming. Before the stroke event, Somsri and Somchat worked together on their own land which was around ten minutes' walk from their house. Somchat had a second job as a labourer in construction while Somsri looked after their children and did housework. Their income was sufficient for living and savings. They had planned to use their savings to buy new land, but all savings were spent on medical treatment expenses. They lived in a post and pier one-story wooden house with open basement. There were small gardens in front of and behind the house for

home-grown vegetables and flowers. Their house was built in the same area as Somsri's older sister's house. After the stroke event, the basement was modified into living space due to concerns about safety and suitability for Somsri. Wooden handrails were constructed around the house for holding and exercising purposes. Her stroke had occurred nine years previously resulting in right-sided weakness. The limb movement on her left side was normal.

In the period of four months following stroke, Somsri needed total care because of right-sided hemiplegia. Somchat became her main carer. As recorded in Table 5.1, he did not take his wife to hospital because one of his relatives and a friend had got worse after admission to hospital suffering from stroke. He strongly believed in traditional remedies and spiritual therapies and that these remedies were more advantageous than hospitalisation. Somsri began walking by herself and doing household work after four months post stroke event. She needed a wooden stick for safety to help her to walk. At present, Somsri could not assist her husband with doing rice farming anymore although she loved to work on the rice farm and felt happy to see the crop grow. Somchat had responsibility for both doing rice farming and caring for Somsri. The care work was minimal; Somchat supported Somsri when she needed help or when he decided that something was too difficult for her.

Somsri looked peaceful and calm. She appeared to be proud of her ability to do daily routine activities like other people although she did them very slowly. In the period of nine years, she had tried many ways for curing her illness, but those treatments did not lead to a full recovery. She seemed to have no expectation of retrieving her full bodily functions after having a stroke, and to be satisfied with her life situation e.g. her movement, her health and relationships with family members. Due to her satisfaction with life, Somsri appeared to accept her abilities, allowing her to combine a peaceful mind and manner.

Somchat looked confident as he talked and replied to my questions quickly and clearly. His caring duties for his wife were presented by telling a story of everyday routine. He could manage his work, his wife and children, even Somsri's older

sisters. He seemed to have confidence in what he thought and what he did which might induce Somsri's thinking. Although he used to have an extra-marital affair after Somsri had a stroke, he appeared to realise his lifelong responsibility to take care of her.

Somsri and Somchat seemed to support each other with positive thinking. They were compatible and thought in the same way. For example, they thought that the stroke event was beyond their control. They agreed that modern treatments could not make Somsri well. They believed in karma and past life. They did not deplore the loss of savings because they thought that the money saved Somsri's life. They did not quarrel with each other despite Somchat's affair with a married woman. It did not mean that Somsri accepted the affair, but she thought that it was fair enough because of her shortcomings as a wife, and she believed in her husband as responsible for the duty of taking care of her and the family. It was clear that Somsri and Somchat lived together with mutual understanding. Situations between them were not constructed as problematic, allowing them to create a life outside or around potential difficulties. The way they thought influenced the way they acted, expressed and managed their emotions.

Pair 2: Pichai (husband-stroke survivor) and Supa (wife-carer)

From more than twenty-eight years of marriage, Pichai (50) and Supa (44) had two daughters (27 and 22). Both were still living at home with them. Their one-story house was built of concrete-brick with three bedrooms, one bathroom, one kitchen, one living room and a garden around the house. In this extended family, there were three generations living together, parents, daughters, two sons-in-law and two granddaughters. Before Pichai had a stroke, he was a tractor driver, and Supa was his assistant. Although Pichai earned more than enough for the family, he had no savings. He spent much money on drinking and partying, angered easily, and Supa had often been physically abused by her husband after his drinking.

Pichai had a stroke and could not move his right side as before. His wife and daughters took very good care of him. He appeared to try to cooperate in everything

his wife wanted, i.e. exercises, although he did not want to do them. It might be because he felt sympathy for his wife. However, he still seemed to get angry easily, but he responded differently by remaining silent and trying to ignore the cause of anger rather than behaving badly. One year after his stroke, he used a cane to help him walk. He appeared stressed and unhappy because he could not move like he used to do. He relieved stress by going out to visit his friends who lived nearby. He had many ways to relieve boredom, i.e. listening to Thai music, watching television, especially boxing programmes, and doing housework. He seemed to be proud of keeping the house clean and tidy.

Supa was his main carer. She shared her care experiences when her husband had needed total care. In the first year after stroke, she seemed to be under a lot of stress and worried about family income and necessary expenditure on her children. She had started to work since her husband had been discharged from hospital. She worked at everything she could because of her intention to look after Pichai and her children with her best efforts. At that time, she took her husband with her when she went out to work. She knew that her husband was very happy to go with her. To date, she seemed proud that her husband could walk by himself, and she built a larger house to replace their former house.

Pichai looked nervous and slightly angry when he struggled to speak because of having communication difficulty. He had stopped drinking because he knew that drinking alcohol made him become hotheaded and hurt Supa. He seemed to feel very bad and realise his mistake in abusing her. Supa had never retaliated for the wrongs he had done her, although she had opportunities to do so. Pichai appeared to feel a lot of anxiety about Supa. For example, he always worried that she could not manage all tasks as a tractor driver because she was unable to fix and repair any damage. He and his wife worked together on the tractor. Although he could not drive, he sat and gave her advice at work. He spoke proudly of his ability with a small smile.

Supa looked very healthy and had many strong muscles. She was willing to take care of her husband and seemed not to think about situations when he used to hurt her.

She understood that he hurt her because of drinking alcohol. She realised that Pichai was a very pleasant man when he did not drink, and he did many good things for her. Now, she had a very happy life because her husband did not drink and was a man at peace. She appeared to be satisfied due to no more abuse. Moreover, she knew how to manage when her husband felt angry. She just ignored it and left him alone. Her husband became friendly and more relaxed within ten minutes. The word 'love' came from Supa, although I never heard this word from Pichai, I could however feel the quality of love and care between them. Sometimes, they had opposing opinions, but it seemed not to be a big problem. For example, Supa believed that karma and retribution were true, and she followed Buddhist teachings seriously, while the teachings had never interested Pichai. This seemed not to matter to them because they did not raise this topic for argument. Their relationship appeared to be open and respectful of each other. They shared what each thought, what each understood and what each did. It appeared that they knew how to manage both each other's physical and emotional issues.

Pair 3: Prasit (husband-stroke survivor) and Somsong (wife-carer)

Prasit (38) and Somsong (36) lived with a son (15) who had growth retardation because of encephalitis at a young age. They lived in a small house with a large garden and two big trees in front of the house. A hammock tied between the two trees was Prasit's favourite place for recreation. Prasit and Somsong had a relationship for over eighteen years. Prasit was a responsible family leader. He held two jobs, a rice farmer and a plasterer. He allowed his wife to stay home and look after their son. He worked hard to collect money for building a new house. Recently, they bought a plot of land next to their old house.

Prasit had a stroke three years ago. For a period of one month after the stroke onset, he was unable to move his left side of the body and was unable to speak, and Somsong gave him total care. After that period, he could walk but not to move as well as he used to. Because of the loss of movement and his stresses, he started drinking which caused him to quarrel with his wife for several months. Somsong begged him to reconsider whether drinking was the best way for his life. That event

made him try to control his feelings, and he found a way of relaxation. He decided to quit drinking and started to practise walking again. He tried to live with his physical limitations. For example, he woke up early in the morning to walk to the rice farm. He practised driving the tractor by using only his right hand. He created a particular way of ploughing to fit his physical ability.

Somsong discussed her responsibility to take care of her husband and their son including housework. Within the first month of the stroke event, she felt discouraged because of all the stresses that she had received. After that period, she was in a terrible situation again when her husband started drinking. She had no money because she spent all their savings on living costs and medical/treatment expenses. Although she fell into debt (300,000 baht) she took him to wherever they heard about good treatments such as herbal medicines, massage and traditional remedies. She believed that Prasit would make a better recovery because of his younger age. She decided to work as a labourer after a two-month period since the stroke event when her husband could walk and help himself. She provided continuing care to her husband while she herself suffered from diabetes and hypertension, illnesses she believed resulted from experiencing a lot of stress and doing hard work.

During interviews, Prasit was calm and spoke slowly. His eyes presented sadness when he talked about painful memories. A sense of responsibility, family support needs and positive thinking seemed to boost him to walk and reach other abilities. He strived to narrow the gap between physical limitations and fulfilling situational requirements in life. Somsong appeared to be very stressed. She always sighed with wrinkled brow even during interviews. It might be her personality and from the experience of dealing with difficult situations. When the family leader was not able to lead, she adapted her way of life to run the family. She also represented herself as a family leader with a brave manner at that time. However, she returned the leader role to her husband when he stopped drinking and returned to the rice field because she knew that the role of family leader was important to her husband. Prasit and Somsong appeared to share open communication: this became evident during observation. They talked freely and respectfully to each other about what they

needed from one another. This may be the influence of having much success in dealing with difficult situations.

Pair 4: Samart (husband-stroke survivor) and Mesa (wife-carer)

Samart (57) married Mesa (42) twenty years ago. He had a son (15), who decided to start working as a farm worker after finishing primary school. It was Samart's second marriage. He had been divorced twenty years ago, and he left his eight-year-old daughter with his ex-wife. Nowadays, his daughter visited him when she needed some money, and he always gave her money to compensate for missing out on his father's role. Samart was a carpenter while Mesa was a labourer in the construction industry. Family incomes were enough for living. Samart regularly had a party at home so he had many friends at that time.

They lived in a small post and pier one-story wooden house with open basement. The house was built within the same fence as his older sister's house. After discharge from hospital, Samart moved to the basement of the house which was changed to living space. The living space had a big table used as a bed, bamboo handrails for holding, a portable toilet created from a bucket and a steel chair and his personal stuff. Initially, he spent most of the time in the bed and needed total care. Mesa quit her job and stayed at home to care for him. Samart was able to walk with a cane eight months later. However, he seemed not to want to walk or even move.

After eight months following stroke, Mesa noticed that Samart had improved, but he refused to move himself and called for more attention. She decided to leave him for work because she had no money for living costs and wanted him to undertake a daily routine himself. She seemed worried about him, but she had no choice. She went out to work in the early morning and came back in the late afternoon. She prepared food for him before she left. She asked his older sister, who lived nearby, to keep her eye on him and told him to shout to his sister when he needed some help or something wrong happened. Their son had barely helped her to take care of his father. He was not close to his parents because of living with his aunt since a young age. He moved to live with them around two years ago after his aunt passed away.

Samart looked bored. His left arm and leg muscles had atrophied a little. He seldom moved his left arm and leg during observation. He has no speech problems. His tone of voice and eyes and postures seemed deeply depressed. He might feel neglected and disappointed with his wife, children, older sister and friends. Samart revealed his thoughts that his wife ignored him and was not willing to help him as usual, that his daughter did not respect him anymore because she had never visited him after he refused to give her money, that his son felt shy for having a disabled father because his son hardly talked to him, that his older sister who owed him 100,000 baht had never returned his money although she knew that he could not work for money anymore, and that his friends never visited him as before. It seemed that he did not have enough inspiration to fight for his life due to changes in situation and dissatisfaction with responses from family members, relatives and friends.

Mesa looked bored when we talked about her husband's exercises and routine activities. Mesa revealed her thought that Samart did not try to do anything by himself and needed her help all the time. She coped with the boredom and the stress of care work by going outside to take some rest and refresh her mind. It appears that Mesa had her own coping strategies for dealing with stresses, but she did not know that these strategies directly affected her husband's feelings. The problem was she did not let Samart know where she went to, why she needed to go out and when she would came back home. There appeared to be a lack of communication between them. Samart and Mesa did not get angry at each other, but they did not know what the other intended, what the other wanted, how the other felt and why the other behaved in that way. They appeared not to talk openly to each other.

Pair 5: Karun (husband-stroke survivor) and Pranee (wife-carer)

Over twenty years of marriage, Karun (44) and Pranee (60) had an eighteen year old son. They owned and took care of a rice farm. They lived in a two-story brick house with their son and Pranee's older sister. Karun had been a community leader for eight years, a position held through election. For the position, he dedicated most of the time to working for poor people in the community with public funds while Pranee provided support for her husband as a backup. Their incomes came from selling rice

products and the monthly salary of a community leader. Karun usually travelled overnight or otherwise brought friends to socialise in his house.

Karun was admitted to hospital due to a sudden stroke. He asked his doctor for permission to leave hospital two weeks after admission. His doctor did not give him permission, but he affirmed his intention to leave although he was not well enough. He developed large pressure sores on his bottom a few months later. He was readmitted to the same hospital because of a wound infection. After three days of hospitalisation, he asked for discharge because he was not satisfied with the hospital services. Another reason was that he did not want anyone to clean his wounds except his wife. Pranee was trained how to look after and clean the wounds by nurses. She strictly followed instructions on dressing wounds, and the wounds were fully recovered after six months. Karun tried to do limb exercises and continued working for his project with public funds although he could no longer write. He expected that he could return to work as a community leader soon. Three months later, he could not walk as he hoped. He always lost his temper and quarrelled with his wife despite it being over little things.

Pranee took care of Karun and took him with her when she went to the rice farm. She was a twenty-four hour carer and knew her husband very well. She supported him in whatever he wanted to do. For example, she disagreed with her husband working for the community after being discharged from hospital for one day, but she helped him fill in an application without any arguments because she knew that he loved this job. She said that she felt bored, moody, frustrated and tired, but she had to control her mind to not show him what she felt. She suppressed the feelings because she did not want to increase his stresses.

Karun would be in a cheerful mood and seemed enthusiastic when he spoke of his work. He looked very proud of what he did for the community. He appeared to appreciate his wife supporting him very much. However, he seemed disappointed with his son who had never paid attention to him since he had a stroke. Pranee knew that her husband was a very emotional man. Before the stroke event, every family

member feared to make Karun angry because he was bad-tempered. As a family leader, members had to obey his orders, especially his son. He used to hurt his son with the handle of a gun. After the stroke event, his son had no interest in him anymore, and seemed not to appreciate Karun. This issue was a big thing affecting Karun's feelings. Pranee tried to explain to both of them, Karun and their son, in order to reach a compromise. Karun understood and tried to talk well with his son, but his son still maintained the same manner. Pranee hoped that their son would understand his father when he grew up.

Pair 6: Umpa (daughter-stroke survivor) and Naree (mother-carer)

Naree (50) lived with her husband (56) and their youngest daughter (14) who was studying grade 8. She did rice farming for a living. She acted as a family leader instead of her husband because he became disabled and could not work as usual after a car accident fourteen years previously. Umpa (25) was her oldest daughter. She had a job as a nursing assistant in a community hospital. Umpa supported Naree by sending money to her every month. Naree expected Umpa to help her support other family members after her retirement. The situation changed after Umpa had a stroke. At that time, Umpa was pregnant, and the baby was delivered during the first week of the stroke event.

Umpa moved in with Naree after getting permission to leave hospital. Naree renovated her house and added one big room for Umpa's family (Umpa, Umpa's husband and their baby daughter). Naree cooperated with Umpa's husband in taking care of Umpa for around six months following stroke. Naree seemed to live under stresses during that time because of frequent arguments and conflicts between her daughter and her son-in-law. She was very tired because she had to do additional work as a labourer in construction in order to earn enough money for all family members. Although Umpa received monthly compensation from the Department of Public Welfare, it was not enough for living.

Umpa made progress in limb movement. She could walk with a three-leg cane two months after the stroke onset. She learnt to live with right-sided physical limitations.

She separated from her husband after six months post stroke, and Naree has become a main carer since then. Naree helped Umpa with preparing food, bathing, toileting, dressing and looking after the baby. Umpa's younger sister helped her to take care of the baby in the afternoons after school and at weekends. Umpa needed to look after her daughter herself and reduce her mother's heavy burden. She believed that she could get back to all normal activities because her stroke happened at a young age. Umpa appeared to suffer from sadness because she became disabled while her life was going well. Umpa seemed unhappy and disappointed with her husband who should take care of her and their daughter. Although she appreciated her mother who looked after her very well, she seemed to have feelings of guilt that she should look after her mother rather than her mother care for her.

Because Naree had experience of caring for disabled people, i.e. her husband, the actual care of her daughter was not a problem. The problem was timing. Naree was only one person in the family to earn a living and look after Umpa and Umpa's daughter all at the same time. In the last two years as a main carer, she became very tired with hard work, but she was proud to see the progression of her daughter's physical ability. Although she seemed disappointed that the stroke event had doomed her expectation of early retirement, she appeared to accept that being a main carer was her responsibility as Umpa's mother.

Pair 7: Nisa (wife-stroke survivor) and Prakit (husband-carer)

Nisa (52) and Prakit (60) had been married for over thirty years and had two daughters. They had separated for seventeen years and resumed living together for one year before the stroke event. Nisa had a small local shop trading in hot food in Nakhon Prathom Province, which was close to Bangkok, while Prakit was a labourer in an orchard next to their house. They supported their daughters to graduate with bachelor's degrees. Their daughters were married and lived nearby. Nisa had a stroke during working hours. She was sent to hospital near her workplace. Prakit came to visit her and asked her doctor to refer her to hospital in Nakhon Sawan Province after a few days of hospitalisation. Nisa was referred and admitted to a community hospital in Nakhon Sawan Province for only one day because Prakit needed to move her to

their own house for using traditional remedies and spiritual methods. Prakit was identified as a main carer and left his job. Their daughters acted as his assistants.

They lived in a post and pier one-story wooden house with open basement, and the basement was adapted for living space and taking care of Nisa. One year post stroke, Prakit ran into debt after he spent much money on curing his wife. He worked very hard because of paying money back. He woke up at midnight for work, and came back home to prepare food and take care of his wife. He then went to other jobs in the morning. He would return home at midday if their daughters could not come to be with Nisa during the day.

In the first year, Nisa seemed to suffer from living alone and learning to do her daily routine by herself. She practised walking without an assistant. She had gradually improved and became able to walk with a cane. The relationship between her and her husband appeared to deteriorate after an argument because she thought that he neglected her, while Prakit was dissatisfied with his wife for lack of respect. They did not talk to each other for several months after the argument until now. Nisa's youngest sister, who lived not far from their house, offered her a job. The job was about the combination of two parts of artificial rose petals. She seemed happy to do this job because she earned for herself, exercised her hands/fingers and had some social contact.

Nisa looked relaxed when we started talking about the general situation of her life, but she started crying when talking about stroke and her husband. She seemed to have a lot of suffering from these issues. Prakit talked at length about his routine activities and his responsibilities during the first year after the stroke event. He cried from the beginning to the end of the conversation. He looked stressed when he talked about his wife's behaviour. The actions of his wife disappointed him. He expected that his wife should feel grateful and pay attention to him. He seemed unhappy and burned-out. However, tears of happiness and laughter appeared when Nisa and Prakit talked about their granddaughter. The source of their conflict appears to be specifically about their interpersonal relationship. It appears that they placed

themselves under stress with frustrated emotions for one another. They still lived in the same house and had some interaction with each other including maintaining their roles.

Pair 8: Duangjai (mother-stroke survivor) and Pracha (son-carer)

Duangjai's family comprised her husband, an eldest daughter and a son (Pracha). They lived in a two-story house. There was a small garage in front of the house. The garage was her husband's business. Before the stroke event, Duangjai was a businesswoman and made a lot of money from her business. Her daughter was a teacher in a primary school and her son was studying at university in Nakhon Sawan Province. Family incomes were higher than the average Thai household income. Duangjai did hard work and planned to retire from her business at the end of the year, but she had a stroke in the middle of that year.

Duangjai (59) suffered a total life change. In the early stage of stroke, she felt upset about her inability to move the right side of her body. She became bored with staying at home all the time and avoided going out except for meeting a doctor. She exercised regularly and could walk with a cane one year later. Three years ago, she lost her father and mother in the same year. She tortured herself for several months with missing her parents and her health deteriorated. The encouragement of her family members made her recover.

Pracha (27) was identified as a main carer because his father and sister had full time jobs. His mother had a stroke in the year he graduated from his bachelor's degree. He received a job offer in Bangkok, but he could not tell anyone in the family, and let them think that he was disappointed at his inability to get the job. It seems that he suffered quite a lot when talking about working because he spoke with tears in his eyes. He thought that he had hypertension at a young age because of stress-related illness. Although Pracha provided the main care for Duangjai, other family members were good supporters. Duangjai's husband looked after her in the morning before he went out. Her daughter did care work in the evening after getting back home. During the day, it was her son's duty.

Pair 9: Sumet (husband-stroke survivor) and Wipa (wife-carer)

Sumet (54) lived in a two-story wooden house with his wife, Wipa (55). They had been married for thirty years and had a son and a daughter. He worked as a truck driver so he rarely stayed at home because of working in different provinces. Wipa lived in Nakhon Sawan Province. At that time, she was a housewife and looked after their children. In personal life, Sumet did not drink alcohol, but he was a drug addict. He had responsibility to send his wife money monthly, and he had an extramarital affair. Because of the affair, Wipa used to leave her daughter and son at home in order to get him back. Sumet's income was quite high but he had no money for savings due to gambling. Six years later, Sumet and Wipa were faced with a very difficult situation when their daughter died in a car crash at seventeen years of age.

The stroke occurred when Sumet worked in Bangkok two years ago. He was admitted to hospital for one week and then returned to stay with Wipa at home. He was very upset that he could not work and take the role of family leader as he used to. He knew that his wife became both a main carer and a family leader to earn a living. He was in a bad mood and worried about his limitations of movement in the first few months of his stroke. Because of his wife who provided very good care for him, he tried to accept his situation and started practising walking again. He could walk within four months after the stroke event. Wipa helped her husband with doing daily routines and encouraged him to exercise. Day by day there had been a gradual improvement in Sumet's right arm and leg. Wipa decided to go to work. She started working all day and every day because their income was reduced. She was willing to do all jobs and still proudly maintained her role as a main carer.

Sumet's and Wipa's life situation was changed when hepatitis B killed their son after six months after the stroke event. They took a daughter of their son (10) to stay with them. Wipa had no day off and had much work to do, including housework, housecleaning to earn money, looking after her granddaughter and taking care of her husband. Around one year after their son died, Wipa was becoming burnt-out because she was not satisfied with her husband's behaviour. She thought that her husband was a very lazy person, and he did not want to recover. He woke up very late and

exercised once a day. He always complained when she asked him to wake up for walking. He had hardly ever done housework. She said that her husband had never asked her how tired she was, and he did not worry about her when she was back too late. It appears that she just needed some moral support from her husband.

Wipa seemed to have no hope after the death of her son because she had expected that her son could support her when she encountered difficulties. She also realised there was only a small chance that Sumet would recover from the stroke. For Sumet, he appeared to lose his confidence as the family leader and was much upset after the stroke event. He felt better when he could walk, but this feeling existed for a short period because of little improvement to right-sided weakness. He exercised in a way that suited him, but he did not explain to his wife about that. He was concerned that his wife worked hard for him, but he said nothing to her. It was clear that they misunderstood each other because of not talking openly. This situation made them have emotional suffering.

Pair 10: Kamol (brother-stroke survivor) and Usa (sister-carer)

Kamol (39) used to live with Usa (53) when he was young before he got married. Kamol had eight siblings. He was the youngest, and Usa was his oldest sister. Usa had two daughters who worked in Bangkok. She was divorced and lived in a one-story brick house with a nephew and a granddaughter (a daughter of her oldest daughter). Usa had two jobs, doing rice farming and working in construction. When her parents passed away, she was like a mother to her siblings. Her siblings always visited her including Kamol.

Kamol had a stroke when he worked as a labourer in Bangkok three years ago. He was admitted to hospital for one week, then Usa took him to stay with her. At that time, his wife provided care for him while Usa assisted her sometimes. Kamol had a lot of encouragement from them. He was proud to slightly move his right hand. Two months later, his wife left him because she must go back to work and look after her children (with her former husband) and her parents. He was very upset over that

issue. Without an argument, he let her go and realised that she would never come back to him. Kamol got worse since then.

Usa became a main carer. She was willing to take care of her brother and tried to comfort him. Taking care of Kamol was very straightforward for her because she was familiar with caring for disabled people. She had over ten years of experience as a public health volunteer. She had undergone training in care of a disabled person at home from health officers many times, and she had won a prize in patient care at home. She spoke of her pride over her care experience. She also had taken care of her mother for fifteen years and her father for two months. Her routine had not changed much because her brother had a stroke four months after the death of her mother. She thought that taking care of her brother was her responsibility because of keeping the promise to her parents to help other siblings as much as she could.

Kamol seemed to feel despair about his wife. He appreciated that his sister had never neglected him and took care of him very well. She helped him do daily routine activities including exercise, and she did not show disgust when she washed his buttocks after toileting. He felt grateful to his sister. He tried to help her housework, i.e. cooking rice, tidying the house and washing clothes. He was silent when his sister complained about him whether he agreed with her or not. He wanted her to be comfortable and happy.

Pair 11: Prasom (son-stroke survivor) and Somjai (mother-carer)

Prasom (47) had a daughter (18) and a son (14) living with his parents. He built a big single storied brick house for his parents in Nakhon Sawan Province, and he visited them twice a month. Prasom worked as a technician in the construction industry in Bangkok. His income was relatively high, and he supported his parents and his children by sending money for them every month. He separated from his wife five months before the stroke event. He was hospitalised for one month in Bangkok and returned to stay with his parents for recuperation. His mother (Somjai) acted as the main carer.

Although Prasom could not work, he still received monthly support payment from his employer 7,500 baht and 8,000 baht from the Department of Public Welfare which was enough for living. He hoped to return to work by April next year because he strongly believed that his symptoms would be recovered within two years. He trusted in Western medical treatment, yet, he tried using different methods, i.e. drinking Ya-Moh, acupuncture, massages and holy water. In the first six months, he received physical therapy at hospital. He exercised and often practised walking in the morning and during the day. When he could walk with a cane, he always went out and stayed in a little hut (a public area next to his house) in the morning and returned home at lunch time or in the evening. He felt relaxed when he stayed there. He met many people and spoke to them.

Somjai (70) was willing to take care of Prasom. She loved her son and sympathised with him. She used to take care of people with stroke (her husband and husband's sister) for many years. Somjai was a main carer and Prasom's daughter was an assistant. Somjai spoke through tears during a conversation. She showed how much she loved Prasom. She therefore was very attentive to him. An additional reason was the thought of depending heavily on her son for the family living costs. She cried because she felt hurt by her son's misfortune but not with the increase in her responsibilities. She knew that her son was not satisfied when she tried to do something for him, but she could not stop worrying about him.

Prasom felt bored and uncomfortable because he could not move the left part of his body well like he used to. He did not want to be a disabled person. Therefore, he tried to do everything like the majority of people did, especially driving. He was very proud to drive a car, and he always drove to his friend's house which it was about ten kilometres from his house. Driving was something that gave Somjai major worry. Prasom angered sometimes when his mother tried to serve him because he wanted his mother to take some rest. He also wanted to do the daily routine himself. However, he still respected his mother.

Pair 12: Mena (wife-stroke survivor) and Thawon (husband-carer)

Over thirty years of marriage, Mena (57) and Thawon (58) had a son (30) who worked outside Nakhon Sawan Province. Their son always talked to Mena every night and visited them every month. They lived in a two-story wooden house located in the middle of the village. Because of an easy-going manner and kindness to people around them, they were persons who were very dear to their friends and neighbours. They owned and worked on a large sugar cane and corn farm. They had good incomes from selling sugar cane and the production of corn. Thawon was a healthy person, while Mena had many problems with her poor health. She had been suffering various pains for many years. She had a pain in her breast for the last twenty years, and she developed backache and leg pain two years later. The pains have gradually increased until now. She still worked on the farm even though she could not walk in a straight line. She has had hypertension for ten years and stopped taking pills for two years before the stroke onset.

The stroke made Mena get severe headache and weakness on the left side of her body. She was admitted to hospital for one week. Because of not recovering from severe headache and left-sided weakness, Thawon asked permission for her to leave hospital to try other kinds of treatments. Mena was brought home. At that time, she took various medicines/treatments, Western medicines, traditional Thai remedies, Ya-Luk-klon which is herbal medicine in the form of a ball for swallowing, massage, injections, spiritual healing rites and religious performances. In the first four-month period post stroke event, Mena was not able to move the left part of her body, and Thawon was identified as a main carer. There were additional carers i.e. her son, her younger sister and her daughter-in-law, who took turns looking after her and helping her to exercise.

Thawon was the main person to design instruments for supporting his wife i.e. a portable toilet, a bamboo rail and a wooden pulley for exercises. He had much care experience because he used to take care of his grandmother and his mother for many years when he was young. After four months after the stroke event, Mena had practised walking until she could walk with a cane and could do some housework.

She seemed to feel good to share the work with her husband. She got severe back pain again three years later. She had suffered from severe pain and gave up walking since then. In the last two years, she always cried herself to sleep some nights and knew that her left leg was weaker than before. She woke up in the morning and did her routine activities while her husband prepared food before going to work outside. During the day, she might do a little housework, but she was not expected to do much.

Mena worried about the pains in her back and legs rather than her left-sided weakness. Although she seemed to accept the weakness due to a stroke and realised that her ability would not be retrieved as full bodily function, she expressed the feeling of depression. She said that the neighbours always visited her, but she did not want to talk with them because she was bored with giving them reasons why she did not walk. She was concerned that no one knew how much she suffered severe pains in her back and legs. It appears that she tried to live with the weakness and the pains. She was in constant pain beneath her smiling.

In summary, all stroke survivors had made some progression in recovering from a stroke. When taking into consideration a period of hospitalisation, they were under health professionals' care in hospital for a short period. The rest of the time was spent with informal carers in the home environment. Stroke survivors and carers dealt with the impact of post-stroke effects together. Stroke survivors had the physical ability to be able to walk without assistance but still needed some help from carers. The relationship between stroke survivors and carers was entirely kin-based. The majority of participants' families were living in poverty which affected the quality of caring for stroke survivors and other aspects of both their lives and their carers' lives including emotional issues.

The low-income problem and economic stress of stroke survivors and carers was found to be associated with having difficulty in living following stroke. For example, Somchat (carer, pair 1) worked in two jobs and spent all his savings on curing his wife of stroke. Mesa (carer, pair 3) had to go out for work and leave her husband

(stroke survivor) alone at home. Prakit (carer, pair 7) ran into debt after he quit his job for taking on the caring role. Wipa (carer, pair 9) worked a seven day week to earn enough money to live and look after her husband (stroke survivor) and granddaughter. It appears that a financial problem disrupts normal activities as a tense situation in their lives, and this leads to a busy life, planning how to manage family- and work-life issues. The problem of poverty inevitably became part of their lives and merged into day-to-day routine activities.

Those stroke survivors and carers carried a financial burden which underlay the context of care and influenced emotional distress in everyday living. Several studies reveal that personal economic stress may be viewed as one of various factors to hinder individuals' quality of life. For example, Caron (2012: 412) stated that the personal social-economic factor could directly or indirectly affect one's quality of life. Similarly, Shek (2005) found that economic stress was associated with adolescents' emotional well-being. Hamilton et al. (2013) demonstrated that an increase in financial stress among hematopoietic stem cell transplantation survivors is associated with poorer emotional well-being and can predict a lower level of their health-related quality of life. It is probable therefore that the economic challenges and financial stress not only impacts on stroke survivors' and carers' daily living, but also has an effect on their quality of life.

This section has provided a description of the participants' personal and family backgrounds. The description was drawn from across the whole data set. The importance of background information is to provide understanding of participants' everyday experience and their social world before and after the stroke event. The context of ordinary arrangements was connected with individuals' practical reasoning to deal with a difficult situation resulting from stroke, causing depression as an impact overall.

5.3 Participants' search for a cure for stroke

Having a stroke leads to significant lifelong disability. Due to a shortage of in-patient rehabilitation and rehabilitation personnel in the Thai public sector, a number of stroke survivors are likely to be discharged from hospital without full recovery, a matter of serious concern for stroke survivors and carers (Kuptniratsaikul et al. 2008; Singhpoo et al. 2009). Perspectives on taking medicines and treatments to cure stroke is introduced here in order to understand stroke survivors' and carers' accounts of seeking a cure for stroke. I focus on what kind of medicine and/or treatment participants undertook after discharge from hospital and why they decided to use those remedies.

Traditional Thai remedies (TTR) were particularly evident in the family home, especially in the early stage when stroke survivors returned home for recovery. The participants always used TTR in parallel with conventional medicines from modern healthcare systems. It seems that stroke survivors and carers aimed to seek the best cure for physical disability following stroke rather than for stroke itself. The World Health Organization (WHO 2002b) gives a comprehensive definition of 'traditional medicine' which is used to refer to the traditional medicine systems of each country and indigenous medicines in various forms which involve using medication therapies, e.g. herbal medicines, animal parts and/or minerals; and non-medication therapies, e.g. acupuncture, manual therapies and spiritual therapies. Traditional medicine is generally named as "complementary, alternative or non-conventional medicine" (WHO 2002b: 1) in public healthcare systems.

With respect to traditional remedies in Thailand, various kinds of TTR comprise medication therapies and non-medication therapies. In my findings, all stroke survivor participants experienced the use of TTR, whereas most carer participants conducted a search for and facilitated access to such cures. Herbal medicines, acupuncture, massages, religious performances and supernatural healing rites were involved in participants' experiences with TTR.

The participants gave different sources of information about TTR. Holding verbal discussions with relatives, friends, neighbours, elderly people and local folk/traditional healers about the benefits of the traditional remedies had a significant influence over participants' perceptions. Advertising on television, radio, magazines and newspapers also was a way they obtained information on TTR (Sumngern et al. 2011). All participants claimed that they heard about positive results with TTR being able to make stroke survivors recover from physical disabilities, and they were keen to try it.

A few participants had experiences themselves in getting good results from TTR. Some participants strongly believed that TTR could cure people of physical disabilities. For example, Somchat (carer, pair 1) stated that he did not take his wife to hospital after facing stroke symptoms because he trusted in the effectiveness of TTR for curing stroke. He gave a further reason, "With respect, I think that health officers have less experience than traditional healers." (line 137) It seems that the reason the participants gave for making the decision to take TTR was in pursuit of their hope of a cure for physical disabilities, and the decision related to their personal beliefs. However, it appears that they sometimes decided to consume TTR with lack of an awareness of its side effects (Disayavanis and Disayavanis 1998; Suwankhong et al. 2011).

Herbal medicines were the most popular remedy. There are five parts of the whole plant traditionally used in herbal medicines, i.e. root, stem, leaf, flower and fruit (Neamsuvan et al. 2012). All stroke survivor participants said that they used herbal medicines with a curative hope, although no folk healers or traditional institutions had received safety approval from the Ministry of Public Health. The participants took herbal medicines in various forms such as fresh herbs, herbal teas/infusions, herbal capsules and fluid extracts.

Ya-Moh is one common form of herbal medicine comprising fluid extracts from mixed herbs (Nilmanat and Street 2004). All participants had information about the evidence of efficacy of Ya-Moh, and all stroke survivor participants had experienced

a drink of Ya-Moh. For example, Supa (carer, pair 2) described her knowledge of Ya-Moh for stroke survivors:

> It consists of many kinds of traditional herbs which are grown locally…I ask village elders and folk doctors for the components of Ya-Moh. I don't know how to get the components so I pay them for collecting ingredients. When I get all the ingredients, I put them in boiling water and stew it. I serve him (her husband) with a drink of Ya-Moh every day...He then gets gradually better. I allow him to stop drinking Ya-Moh around one year after stroke (line 294-296).

Supa described the preparation and her source of Ya-Moh. She seemed to believe that her husband derived benefits from drinking Ya-Moh. She added that Ya-Moh did not cost her much money, and she could afford to buy it. Similarly Prakit (carer, pair 7) bought Ya-Moh and herbal teas from a local doctor and paid only three hundred baht a week for that. It is similar to other participants who showed a willingness to use Ya-Moh and herbal medicines. They also knew how to obtain those medicines. There were different recipes for herbal medicines which were based on the knowledge and experiences of folk healers (Chotchoungchatchai et al. 2012; Suwankhong et al. 2011). Ya-Moh and other herbal medicines seem to be the first choice for dealing with physical disability.

Having traditional Thai massages (Nuad-Jub-Sen) was reported by all stroke survivor participants. Nuad-Jub-Sen is the method of applying pressure on muscles together with passive stretching by using "the thumbs, palms or elbows to control the mechanical pressure applied during massage, directly pressing on the meridian lines called Sen Sib, and focusing the pressure on specific points on these lines" (Buttagat et al. 2012: 58). In Prasit's words (stroke survivor, pair 3), "I think massage is the best way of enhancing flexibility. I felt relaxed and strong after having that" (line 89). On the contrary, Somsri (stroke survivor, pair 1) said that she stopped going to Nuad-Jub-Sen because it made her feel sick.

Other forms of TTR were reported by many participants. For example, Samart (stroke survivor, pair 4) always rubbed spiritual oil, which he received from an elder monk, into his left hand and leg. Prasom (stroke survivor, pair 11) went to herbal

sauna which he believed might stimulate his muscles to become stronger. He received acupuncture as well as Umpa (stroke survivor, pair 6). Somsri and Mena (stroke survivors, pairs 1, 12) went to spiritual healers with the aim of removing their bad luck. In relation to spiritual beliefs, Samart, Duangjai and Mena (stroke survivors, pairs 4, 8, 12) and Supa, Wipa and Usa (carers, pairs 2, 9, 10) stated that they had a preference for religious performances such as paying respect to the Buddha's image, praying to Buddha, offering food to the monks, listening to special sermons and making merit as a way of being hopeful and having a peaceful mind.

Besides using TTR, the use of injections by a quack (Mor-Chit-Yaa), who makes false claims to be a doctor, was popular. All stroke survivor participants had the experience of being injected by quacks at least once. Carers either took stroke survivors to quacks or collected quacks from their houses to give the injection. The participants appear to believe that Mor-Chit-Yaa had knowledge of curing physical disability as Kamol (stroke survivor, pair 10) indicates here:

> When drugs are injected into my blood vessels, I feel warm throughout my whole body...I keep going to meet him (Mor-Chit-Yaa) and have an injection every month. I feel that movement in the right of my body is better than before (lines 21, 27).

There were six participants who asserted the same feeling as Kamol. They then returned to those quacks with hope of recovery. Thawon (carer, pair 12) claimed that his wife got better after having daily injection from Mor-Chit-Yaa for five days. However, most survivors gave up injections because they were not showing any signs of improvement.

In summary, the existence of TTR plays an important role in Thai health systems, and it is integrated into local people's minds. Stroke survivors and carers used TTR as an alternative way to cure physical disabilities following stroke. The use of TTR was deemed by all participants to be normal, and this was connected with local systems of personal beliefs and practices. Although some TTR called 'Phaet-Phaen-Thai' are incorporated into Thai public healthcare systems, e.g. Nuad-Jub-Sen, some types of Thai herbs, herbal steam bath (sauna) and acupuncture (Bodeker et al. 2005;

Buttagat et al. 2012; Del Casino Jr. 2004; Disayavanis and Disayavanis 1998; Robinson and Kuanpoth 2009), it appears that the participants chose to meet local traditional healers instead of health practitioners in hospital.

5.4 Conclusion

This chapter describes stroke survivors' and carers' family backgrounds and adaptation to life after the stroke event. The data presented reveal how they thought about their situation, how they understood the survivor-carer relationship and how they managed their roles following stroke. The perspectives on taking traditional Thai remedies following stroke provide a detailed understanding of participants' experience through using accounts of ordinary affairs and practical reasoning to deal with difficulties in everyday living.

The findings of this chapter indicate that stroke was a life changing event and a traumatic incident for stroke survivors and carers. Attention has been given to how they adapted their lives to meet their changed situations. Understanding individual contexts of ordinary activities is beneficial for studying stroke survivors' and carers' common-sense knowledge and their methods of engaging in emotion work during caring interactions from my point of view as a researcher.

Taking an ethnomethodological approach explicitly focused on emotion and identifying the process of stroke survivors' and carers' emotion work which allows the study of mundane details of their interactions and how they account for ordinary affairs. The way stroke survivors and carers co-constructed the care environment in the family home provided understanding of how individuals made sense of their world influenced by culture and circumstances.

The next chapter will draw attention to what beliefs stroke survivors held regarding the stroke event in order to understand their social world and ordinary activities. The purpose is to reveal their practical reasoning behind stroke survivors' decisions around achieving emotion work during caring interactions with their carers.

Chapter 6

Stroke Survivors' Accounts of Their Beliefs about the Cause and Effects of Stroke

6.1 Introduction

Stroke survivors' accounts of their beliefs about the cause and effects of stroke emerged as a main theme of stroke survivors' experiences following stroke. This theme is comprised of four subthemes, i.e. stroke survivors' experiences of the first six months post stroke, stroke survivors' reasoning with themselves about the cause of their stroke, stroke survivors' attitude towards themselves, and stroke survivors' attitude towards carers (see also Figure 4.1, p. 89). These subthemes are strongly linked to how stroke survivors managed and expressed their emotions in everyday life. The stroke survivors' accounts of their beliefs were gathered by taking an ethnomethodological view during the analysis of the data. Deriving a sense of how individuals exhibit behaviour in everyday activities comes from their common-sense knowledge and awareness of the basic rules of their social world (Garfinkel 1967; Maynard and Clayman 1991).

The natural place of indexicality is situated in phenomena such as usual occurrences and individuals' existing activities displayed and recognised in their ordinary social life. Identifying indexicality is viewed as a particular problem which needs formulation (Bowers 1992; Garfinkel 1967; Goodman and Strange 1997). Stroke survivors' accounts of their beliefs which might produce an action or a way of behaving in daily life are used here for explaining indexical expressions. For stroke survivors, the everyday feeling of being certain a stroke existed and that they were continuing living with the effect of stroke were demonstrated as problematic for the survivors through indexicality. Therefore, the significant influence of stroke survivors' feelings and of setting a value on themselves and carers was important in exploring the way in which stroke survivors constructed their emotions and how emotions were organised during caring interactions in everyday lives.

This chapter is structured as follows. Firstly, the effects of stroke experienced by stroke survivors in the first six month period is briefly described in order to provide understanding of their existing conditions. Following on from this a description of how stroke survivors established the cause of their stroke event is given for exploring what they thought about the reason why a stroke occurred to them. Then, a discussion about stroke survivors' evaluation of their own ability is presented for understanding individual responses to the difficulties in their lives. Finally, the overarching aspect of the opinions that stroke survivors had of carers is described in detail. The word 'participants' in this chapter refers to stroke survivors, and the numbered pairs are identified for making a link between stroke survivors and carers.

6.2 Stroke survivors' experiences of the first six months post stroke

As discussed in Chapter 2, the symptoms of a stroke occur unexpectedly with a rapid onset which results in a radical and permanent change in stroke patients' lives. Stroke survivors have always suffered negative effects on most aspects of their lives as a result of varying levels of disability (Mant 2011; NHS Quality Improvement Scotland 2005; Stroke Association 2012b). Greater attention has been given to stroke survivors who were younger adults because they encounter a major change in their lives and might spend the rest of their lives with more or less functional disorders, and a considerable amount of literature has been published on long-term effects of stroke outcomes (Green and King 2010; Kuptniratsaikul et.al 2009; Manimmanakorn et.al 2008; Naess et.al. 2010; Thompson and Ryan 2008). Mobility impairment and the problems of life satisfaction after stroke are reported widely, and there is concern regarding ways to improve stroke survivors' quality of life (Carod-Artal et al. 2000; Jaracz and Kozubski 2003; O' Connell et al. 2001; Singhpoo et al. 2009).

This section considers the impact on stroke survivors in the period of six months post stroke. Eleven of twelve participants who survived a stroke were discharged from hospital to their own home and continued to live with impaired physical movement and functional limitations. One participant did not go to hospital during the acute phase of the stroke. Of course all of them became stroke survivors from then on;

however, all stroke survivors reported having at least one underlying disease, e.g. hypertension and diabetes, which were expected to be at high risk of increasing after having the stroke. After discharge, all stroke survivors had repeated visits to hospital and had taken the usual medications for their chronic illness. Even the individual who did not attend hospital in the acute phase still goes to hospital.

From the hospital in-patient data, no one stayed longer than two months; the average period of hospitalisation was 2.63 weeks. After discharge from hospital, stroke survivors appeared to focus on the problem of their impaired physical function due to mainly affecting their private, family and working lives. All stroke survivors talked about the need for total care at home as a result of being unable to move one side of their body. Stroke survivors needed help from carers to perform routine activities and exercises. The carers became intimately involved in stroke survivors' lives. It appears that stroke survivors' recovery process mostly occurred in the family home rather than in hospital, and the progression of their physical movement was accomplished by close collaboration between stroke survivors and carers.

A considerable factor in the improvement towards recovery from a stroke was the difference in age. A recent study by Knoflach et al. (2012) reported that patient age was a significant predictor of three-month functional recovery among patients after ischaemic stroke. Young stroke patients may have better functional outcomes than older patients. According to findings from my study on this issue, six stroke survivors were diagnosed with having an ischaemic stroke. They identified the duration of their decreasing degree of physical disability and dependence on carers following stroke from two months to one year. There was a tendency for better functional improvement among younger stroke patients. However, some older stroke patients were better at physical function than the younger ones. Also in my data, in addition to age, there appear to be other factors influencing body functional recovery following stroke. This would depend a lot on personal circumstances and personal characteristics.

All stroke survivors reported that they experienced various difficulties in living with effects of stroke, i.e. physical impairment, emotional distress, changed role and changes in their social life. They seemed to be concerned with the great changes in their physical difficulties. For example, Somsri (pair 1) said: “Most people used both hands. I could use only one hand” (line 63). In Duangjai’s words (pair 8): “When I tried to lift my right leg, I felt heavy in the leg” (line 140). Prasit (pair 3) described his lack of feeling in the left side of his body. Prasit said: “I was in consciousness and thought that I was able to move my body, but I couldn’t. I could move only right side of my body” (line 91-92). Prasom (pair 11) described his physical changes:

> I was so exhausted...My left hand became loose. I could not move the left side of my body. When I wanted to raise my arm, it seemed like my arm was forced by both downward pressure and lift at the same time (demonstrating) (line 4-6).

Six stroke survivors reported the experience of communication difficulties or aphasia, having problems with speech, writing and comprehension, during the initial stage of a stroke (Stroke Association 2012d). In the data collection period, five stroke survivors still retained difficulty speaking, and all of them had right-sided weakness. As they had previously used their right hands to write, they could not communicate by writing either. They also had a limitation on their ability to understand something completely as they had been able to in the past. Speech disorder was the most important problem for communication with another person in everyday living (Stroke Association 2012d). They appeared to feel frustrated when these speaking difficulties occurred. As time passed, the speech problem became a part of their character whether they liked it or not. Their speech was understandable, especially to carers who were familiar with their speech. It was shown that having difficulty in communicating might contribute to the feeling of frustration for the survivors. However, the communication problems were not too significant in their lives because they created other ways to share information with other people such as using body language and other signals. It seemed that they had accepted and become used to living with their impaired communication.

Emotional changes were noted as being a common problem following stroke. No one had symptoms of Pseudobulbar affect (see also p. 16). All stroke survivors experienced emotional suffering, e.g. sadness, worry, pain, fear, uncertainty, loss of confidence, anxiety, depression, stress, upset, anger, and loneliness. Alongside unexpected illness, limitation on physical activities, the loss of control of their lives, loss of work, friends, social activities and financial problems were reported by stroke survivors as the leading causes of changes to their emotional well-being. All stroke survivors described their feelings as being tense and discontented about their mobility impairment. All stroke survivors experienced stress related to disabilities. For example, Kamol (pair 10) expressed his frustration at being unable to control movement of his right arm intentionally. Mena (pair 12) said with tears in her eyes, "I was sad when I thought about it (stroke)" (line 167). Nisa (pair 7) said: "I am tortured. I used to be able to do so many things. I cannot do the same things anymore" (line 15). It is clear that stroke survivors suffered from the emotional impact of stroke.

Some male stroke survivors felt embarrassed about letting their wife do a job to earn money. They also felt that they had lost their role as the family leader because they themselves were not able to return to full-time work. For female stroke survivors who were in the family as a wife, their role was changed. Two of five female survivors experienced their husbands' having an affair. One female survivor got divorced after the stroke event. As part of the changes to their social lives, there were at least five survivors who suffered from social isolation. The consequence of role and interpersonal relationship changes represents a serious impact on stroke survivors' family and work lives.

In summary, this section reveals stroke survivors' difficult experiences of living and how their life changed following stroke. Stroke survivors managed to overcome physical difficulties, communication problems, emotional changes and gender roles in their everyday living. They also suffered from multiple coexisting diseases. The findings are demonstrative of the need for care at home. The younger age at onset of stroke was only one of many contributing factors in the speed of their recovery. This

information concerning the significant aspects of their life experiences occurring in the first six months post stroke was described in order to identify the trajectory of stroke survivors' life changes in the early stages of stroke. The physical and emotional impact of stroke on stroke survivors may shape their personal self and perspectives on life.

6.3 Stroke survivors' reasoning with themselves about the cause of their stroke

The emergence of a subtheme, namely stroke survivors' reasoning with themselves about the cause of their stroke, reflects one of the substantive issues in presenting the theme of stroke survivors' accounts of their beliefs. This subtheme is concerned with stroke survivors' constructions of their reasons and beliefs regarding where their stroke came from. They attribute three main reasons for having a stroke- those who believe in karma, those who give a more scientific reason, and a mixture of the two. These reasons emphasise individual aspects shaped by the survivors' personal beliefs. Understanding these ideas enables discovery of the facts of the connection between personal beliefs and established thinking about their stroke that affected stroke survivors' behaviour and emotions in everyday lives.

The first reason is the occurrence of stroke as a result of fate or karma. This idea is closely related to beliefs in the Buddhist faith. Four stroke survivors stated that they had a stroke resulting from their past deeds, and this gave them a sense of what they had done in their previous lives. Somsri (pair 1) described:

> I have never made a full recovery from a stroke. It (stroke) has to be like this...It has already happened. I must accept my fate (line 134-135)...They (older people and folk doctors) told me that it is because of bad karma from my past deeds. It (stroke) cannot be cured. It is a karma illness (line 163-164)...I believe what they said to me because there are not any causes except this cause (line 226).

According to Somsri, she had a complete idea that her stroke was an illness forced by her own bad actions in a previous life, and the condition of her stroke could not be

altered. The account of her belief about the origin of her stroke demonstrated influence from her religious belief. An additional factor enhancing the belief was from her experience with other people who have the same idea. This situation appears to be a general belief of her social group. Furthermore, because of having never made a perfect recovery, the reason that Somsri used to explain to herself why her stroke could not be cured was down to her fate. This seemed to make her have peace of mind to accept an inevitable fate. The belief about the process of karma in Buddhism fuelled her calm as she said:

> I have not been feeling stressed. I accept it (stroke). It has already happened (line 70).

Similarly, such thinking about the process of karma influenced Kamol (pair 10), who also saw a stroke as his own fate. This idea also contributed to his peace of mind. Kamol described:

> I have no idea what can I do. I just let it be...I must restrain my mind and control it. I cannot walk as before. Sometimes, I think about it (stroke). I feel tense, but I can do nothing because it has already existed (line13-14).

Kamol indicated that the force of bad karma was the cause of his stroke. Kamol said: "I believe that it (stroke) comes from the result of my bad karma. It makes me be like this" (line 127). He also considered the possibility whether drinking alcohol caused his stroke. He said: "Many people drink, but they do not have a stroke. I do not know why it (stroke) happens to me." (line 128)

Duangjai (pair 8) accepted the occurrence of her stroke because she believed that she was receiving her bad karma. Duangjai said:

> I have my own karma. I must live like I am now (line 80-81)...It seems that bad karma reaches me. I was born in order to be responsible for what I used to do. Now, I just always do good deeds (line 86-87).

The above excerpts indicate that Duangjai also believed in karma as a process of returning the result of her deeds done in past life. A further participant reported having a strong belief about her misfortune. Nisa (pair 7) described:

> I believe that doing good things cause good results, while doing bad things cause bad results...I also believe in previous and future lives. I know that I do good things in my present life. I have no idea when I did evil deeds (sighing). It is my bad karma which I did bad things in any previous lives. I am like this in present life...I do not know whether karma is real or not, but I still believe about that (line 250-252).

In all, one-third of stroke survivors believed that the occurrence of a stroke came from their own karma. As discussed in Chapter 2, beliefs about the law of karma were embedded in Thai Buddhists' accounts. With regard to previous, present and future lives, individuals will receive the beneficial or harmful effects from what they used to do by way of good or bad deeds respectively as the law of return (Egge 2002; Payutto 1993). Although karma is invisible, these stroke survivors presented a strong belief in the process of karma and the results of actions from their previous lives. It ruled their current life situation. The beliefs contributed to at least a sense of understanding and resignation, leading to being able to stay calm and achieve some peace of mind. It also influenced their account of accepting his/her life situations with an effect on their thoughts, emotions and actions.

The second reason given for a stroke is that it was caused by a disease of his/her body. In the findings, three stroke survivors gave scientific reasons as to the cause of their stroke. Umpa (pair 6) stated that her stroke was caused by a lot of stress induced by both personal and work problems. Prasom (pair 11) indicated that he had a stroke due to high cholesterol. Mena (pair 12) decided that her stroke came from her health behaviour. Mena said that it was because she has had hypertension for ten years and stopped taking pills for two years before stroke onset. Mena described:

> I have never done any bad things...I think the opposite way whether karma is really true. It is invisible. I cannot prove it (line 125-126)…I would like to believe the process of karma, but I am not sure whether it is true or not...I realise that my stroke did not come from bad karma. It was because I do not like to take pills and to see doctors. I always ignore my illness (line 185-187).

For Mena, her stroke was reasoned in a scientific way based on the evidence of personal experience about her illness. For Umpa and Prasom, they had basic knowledge of stroke. Umpa worked as a nurse assistant in the medical department.

She graduated from high school and received some hospital training so she had some background knowledge of a stroke. It is not surprising that she only raised medical reasons to explain the origin of her stroke. Prasom graduated with a High Vocational Certificate and worked in Bangkok, and he also had a high income. When he had a stroke, he was sent to a private hospital where he received detailed information about his stroke. It seems that both of them had a scientific perspective because of having some medical knowledge.

However, five stroke survivors presented the beliefs as related to both reasons. For example, Prasit (pair 3) talked about the cause of his stroke. Prasit said, "It came from high cholesterol" (line 73). He trusted in his doctor and followed the doctor's suggestions. He also thought about the law of karma:

> Sometimes I think that it is my fate. In my previous lives, I might do something bad to someone. I then received the result of those actions in the present life. I think in many ways that make me be resigned to my fate (line 31-32).

Karun (pair 5) had the same idea. He realised that excessive drinking caused his stroke. He also thought about good/bad karma at the same time. Karun stated that thinking in the way of Buddhist teaching drove him to cope very well in some situations in his life. Sumet (pair 9) claimed that he used some Buddhist doctrines to suppress his feelings and emotions, but he did not believe in the process of karma. Similarly, Pichai (pair 2) said, "I would not like to believe karma" (line 121). Pichai mentioned that he did not exactly know why a stroke occurred to him. He just believed that his stroke did not come from his bad karma. For Pichai, it was not a matter of finding the cause of his stroke because he gave his attention to how he continued living in daily life. This approach was echoed by Samart (pair 4). He seemed interested in trying to get better from his physical limitations caused by a stroke rather than discovering where his stroke came from.

In summary, this subtheme explores stroke survivors' accounts of their beliefs about the occurrence of their stroke. The importance of discovering how the survivors thought about the cause of their stroke is not only to reveal individuals' personal

beliefs and values, but also to understand how they take their own beliefs to establish their emotions and feelings including gaining acceptance in their life situations. The subtheme relates to both spiritual and scientific beliefs. The beliefs in the law of karma and other Buddhist doctrines are basically things to hold in stroke survivors' minds for keeping calm. These spiritual beliefs appear to be a psychological anchor for the survivors to keep their life in balance, whereas the scientific beliefs seem to support them with logic. It can be said that these beliefs contribute to stroke survivors' strategies to make it easier to manage their emotions in everyday living.

6.4 Stroke survivors' attitude towards themselves

Stroke survivors' attitude towards themselves emerged as a subtheme through the presentation of substantive issues raised by stroke survivors. The subtheme appeared from a number of interviews and observations which concerned the stroke survivors' descriptions of having feelings about their own health status, how their accounts developed and how everyday routine lives were associated with the way they thought about their health. It became apparent that the way stroke survivors evaluate themselves was a major factor in their assessment of their own ability. This subtheme was divided into two preliminary categories, being ill and being stable with physical limitations.

6.4.1 Being ill

The act of thinking of themselves as being ill was a very real barrier to stroke survivors' life post stroke. The main factor which appeared to be influential against stroke survivors maintaining a positive evaluation of self and self-esteem was the way in which they had negative feelings about themselves, especially in connection with mobility impairment. There were two factors developed as the reason that stroke survivors evaluated themselves as a sick person.

The first factor was the condition of full recovery from stroke. Samart (pair 4) and Karun (pair 5), who had a stroke for nine and ten months respectively, believed that

they still had symptoms of stroke and complications post stroke including signs of additional illnesses. Those signs and symptoms made them have left-sided weakness, and it was a physical handicap for achieving their family, work and social lives. Furthermore, physical limitations caused most of their emotional distress, especially anxiety and depression. The issues around the thought of suffering from illnesses were indicated:

> There is one more thing. I got an abscess on my buttock (left side). I had an operation to remove it. I didn't know whether something was wrong or not. The left side of my body gets worse. It has never got better...After the operation, I couldn't walk at all (line 148-150)...I have no idea whether it is a dislocated bone. There is a small hollow (pointing at his left shoulder)...A local osteopath told me that it was fine. It was no dislocation of the bone. Sometimes, I used to move it (the shoulder). I heard noise coming from this point. It looked like the bones were not connected (Samart, line 153-155).
>
> I want to use the toilet comfortably, but I cannot do it. I feel pains across my whole body. I also cannot raise my hand (line 110)...Today, I got a pain here (pointing at his left leg). Yesterday, I did not feel like this (Karun, line 282).

The above excerpts demonstrate the reasons why Samart and Karun considered themselves as remaining ill. They took more of an interest in physical limitations because of the effects on carrying out a daily routine and working. It appears that they accepted impaired physical function following stroke, but symptoms of other illnesses made them unable to move as usual. The symptom appearances influenced their thinking about their health status. Samart thought that he could not walk because of complications resulting from the abscess incision, and his left shoulder was not controlled normally due to a dislocated shoulder. Similarly, Karun saw his pains as causing the limitation to his physical movements. These problems appeared to be prioritised as the most important obstacles to their everyday living such that they should deal with them first.

The second factor which signalled the thinking and views about still being ill was the need for treatments and medications for improving from illness. It also supported the first factor. Evidence from the findings indicated that Samart and Karun still sought many ways for curing their illnesses. They seemed to pay attention to traditional/folk

remedies and religious performances rather than Western medicines. For example, Samart always applied and rubbed massage oil consecrated by a well known Buddhist monk on his left shoulder, arm, hand and leg to relieve pain and for muscle relaxation. Karun planned to go to Kanchanaburi Province to meet a famous local masseur. The following excerpts show examples of the alternative treatments they used and how these remedies related to beliefs about their illnesses.

> My neighbour has never taken any Western medicines. He became well again. He can walk now (line 30)...Some people have had a stroke for ten years. They can walk now...They drank Ya-Moh (line 45)...I went to hospital. A doctor said that it was all right (his left shoulder). I wondered why I had never had the small hollow here (Samart, line 156).

> I drank herbal liquid from Taiwan. After drinking, I felt like as if I had needle injuries on my legs (line 66)...I also drank Borapet, a Thai herb pickled in liqueur. My legs were very warm after drinking it (Karun, line 70).

All participants confirmed that they took modern medicines from hospital. They also sought other ways to cure an illness in order to recover from functional impairment. There were various kinds of therapies, e.g. traditional/local herbal remedies, massage, spiritual religious performances and supernatural healing rites (see Chapter 5). Their beliefs about seeking alternative remedies related to their experience and perception of curative hope and the superstitious power which appears to be embedded in Thai culture. The findings revealed that there were many sources of information about various treatments/medications, e.g. through word of mouth, self experiences and advertising.

Associated emotional distress is notable as having a significant impact on stroke survivors. Samart and Karun suffered severe depression as a result of maintaining negative feelings about their health. Samart used to drink and smoke regularly in the past. After the stroke event, his wife and son did not allow him to drink and smoke anymore. He could stop drinking but could not quit smoking. To stop smoking seemed to be one of the most important things inducing his stress. The stress gave him severe headaches. He always asked his wife and son to buy some tobacco for him and tried to explain why he needed to smoke. His wife and son ignored his

request because they wanted him to quit smoking. He thought that no one was interested in this issue and consequently it made him feel lonely. He then solved this problem by taking twelve pills of Paracetamol a day to relieve pain. The pain was reduced, but the tension inside persisted. Day by day, Samart stopped asking for tobacco despite having headaches. He was very upset due to this issue, which drove him to feel unworthy in his family. Samart often returned to talk about this issue of unworthiness and showed very much concern and expressed very strong feelings of unhappiness. It appears that stress contributed to his depression.

It illustrated that Samart became very depressed. Samart said: "I don't want to walk. I don't want anything else. I feel inactive. I don't care whether I can walk or not" (line 15). The possible causes of these feelings might come from everyday experiences with his wife and son and the physical disability issue as the quotation below shows:

> I used to shout at her (his wife). I didn't know why. I couldn't explain my mind, I was thinking continuously. I thought how to return to work; how to make money for supporting the family (line 61-62)...She came back home too late. I worried about her (line 66)...She talks to me some days. She went out to talk to her friends...I want her to talk to me. I also want my son to talk to me, but he doesn't come to talk...I tried to beg him to have a conversation. He didn't come (crying)...I thought that he might be embarrassed with other people because he had a disabled father (line 79-82).

This is reminiscent of Karun, who suffered from anxiety and depression. Karun said:

> I worry about people around me, especially my wife. I feel very worried. I am afraid someone might hurt her. I used to participate in local politics and I was afraid of revenge being taken out on her (line 33-34).

Karun lost confidence and power because of physical impairment. Karun was positioned as a leader and had great power both in the community and in the family. Furthermore, his son's poor manners and disrespect affected him. The following excerpts show signs of Karun's feeling of depression:

> I am dejected. I might meet you for the last time. I feel hopeless... Formerly, I had a lot of energy to fight for my family. Now, I feel completely hopeless

(line 268-269)...I worry whether I am a heavy burden to her or not...I want to commit suicide ten times a day (line 275-276).

It is not only the presence of physical symptoms and the need for treatments and medications associated with physical limitations following stroke that caused the belief about being ill, but also severe depression was raised as a significant impact on stroke survivors who had negative feelings about themselves and a low estimation of their own competence. This may be connected to lack of self-confidence to engage in everyday activities. Korpershoek et al. (2011) carried out a systematic review, and seventeen articles in relation to the importance of self-efficacy influencing post stroke recovery were included. They found that stroke survivors with a sense of high self-efficacy were able to perform daily activities better than the survivors who had a low self-efficacy. Stroke survivors with high self-efficacy were significantly less depressed (see also Salbach et al. 2006). It implies that stroke survivors who believed that they were still sick correspond with them having low self-efficacy.

The dramatic decline in social activities that occurred after the stroke event affected stroke survivors' feelings. It has been linked to their depression (Thompson and Ryan 2008). It appears that living in their home with carers and family members became stroke survivors' social life. Individual self and social world are very close and dynamic in influencing individuals' self-construction (Forgas and Williams 2003). Therefore, the feeling of loneliness and being far from former social circles may contribute to severe depressive symptoms among stroke survivors.

These stroke survivors expressed that they were still ill. Trying to seek a cure for the illness was their first priority. They had a dependence on carers for both physical and mental support and showed the feeling of wanting to receive the same attention from carers and family members as they used to obtain during the early stage post stroke. They also showed the signs of emotional distress, especially depression. These factors influenced their behaviour and emotional expressions. However, this was only one way in which some stroke survivors viewed their health status. The next section illustrates a contrasting attitude towards health status and different thinking patterns.

6.4.2 Being stable with physical limitations

Although all stroke survivors had a strong desire for having the same competence in physical functions as they had before having a stroke, at this point of their stroke trajectories most of them indicated that they had achieved a stability of body functions. For long-term functional outcomes post stroke, the survivors illustrated insight into their perspectives on living with physical impairment as a matter of routine living. This meant that they accepted limited physical ability to carry out daily routines. The problem of the severity of physical impairment had also been overlooked.

Ten stroke survivors spoke of accepting a permanent physical disability post stroke. For example, Prasit (pair 3) said: "It (stroke) has settled. I can walk but not the same as before. It didn't change. It has neither got better or worse" (line 41). Somsri (pair 1) talked about her health status: "It (stroke) has never completely recovered...I don't think that it will ever get better. It is as good as it can be" (line 51-52). Duangjai (pair 8) shared her experience of cures for stroke and their outcome:

> I did everything over the first two years. It didn't work...I had injections, saw some local quacks and drank Ya-Moh, but the results weren't good enough...Over five years it (physical function) is better, but it hasn't recovered (line 182-183).

Sumet (pair 9) raised similar issues and described how this insight had led to his satisfactory progress in walking ability:

> I am like this (having limited physical ability). I accept the situation. It is similar to other people who have had a stroke. Like me, they cannot walk normally (line 84)...It (stroke) has already happened. I can do nothing. I cannot go back to the same life. Although it is getting better, I haven't made a full recovery (line 91).

The above excerpts from some stroke survivors showed the acceptance of the disruptive element to their usual lives. They realised that they could not continue living like they had before. They were part of a minority group of people who had

lives with functional limitations. It directly linked to what they thought about their competence in daily living and how their thought on their everyday lives was shaped.

There are two issues developed as a result of the survivors' thought about having stable physical ability, i.e. trying to do their daily routine and/or housework themselves and adapting to work for a living. The first issue was that these survivors tried to perform activities by themselves as much as possible for various reasons. Most of them reasoned that they needed to lighten carers' workload. For example, Umpa (pair 6) avoided asking her mother to help her with looking after her daughter because she wanted her mother to take a rest after getting back from outside work. Pichai (pair 2) used free time for cutting the grass, tidying the house and preparing food for family members although he had never done these activities before the stroke event. Additional information relating to this issue is provided as follows:

> In the past, I rarely did housework because I was afraid of getting worse. Nowadays, I think that as it has never got better than before it can also not get any worse. So I do whatever housework I like (Mena, line 234-235).
>
> When I started walking, I could wash my clothes and cook rice (line 46)...I did it to lighten my sister's housework. At least she did not clean my clothes (Kamol, line 48).
>
> I just try to help myself. I always prepared food for her (his wife) when she came back home quite late (Sumet, line 92).
>
> I think that he (her husband) is tired from his work and also from looking after me...I try to help him as much as I can to reduce his tiredness as much as possible (Somsri, line 48-49).

Other reasons why stroke survivors practised their physical movement were added. For example, Prasom (pair 11) needed to preserve his independence. He tried to do everything like he had before his stroke onset. He was very proud to drive a car himself in particular. In Prasom's words:

> I must adapt to everyday living. I must be able to take responsibility for my daily routine. I don't want to bother other people (line 71-72).

Getting exercise was Nisa's reason (pair 7). She pushed her wheelchair to move around her house and to go somewhere instead of just sitting in the wheelchair. This method could help her walking progress.

The second issue influencing stroke survivors' attitudes to everyday living was their return to paid work. Four stroke survivors were involved in this issue (Pichai, Umpa, Nisa and Prasit). Having a job made them proud and allowed them to continue their lives almost the same as the majority of people who had both family and working life. Pichai (pair 2) and his wife worked together in the field with a tractor. His responsibility was to repair broken tractors and to be a consultant because he had more than ten years experience in working with them. Umpa (pair 6) had a dream to open a small convenience shop in front of her house. It implied that she evaluated her own ability as unable to get back to work as a nurse assistant again, so she thought further about finding some appropriate work to earn money. At present she had some small shelves located in front of the house to sell snacks. She appeared to be happy to have a job although she got very little money from this business.

Nisa (pair 7) received little money from her job, the manufacturing of artificial rose petals, but she described many benefits from her work. Firstly, she had a chance to exercise, having half a kilometre's walk from her house to the workplace. Secondly, doing this job improved her finger and hand movement. Thirdly, she felt relaxed during working hours. Finally, it increased her social life and gave her the opportunity of talking to other people. Prasit (pair 3) intended to be a farmer and return to work in his rice farm like he had done before the stroke event. He was very proud to succeed in his job. Prasit said:

> I know that I cannot fully work in the field. I can plough the field to grow rice but with the inconvenience of being unable to use both hands equally. I develop my own method to manage it...In the earlier times, I faced some problems. Now, I am accomplished at ploughing (line 42-43).

All these survivors indicated that their health was remaining in the same condition (i.e. stable), with some residual limitations on their physical functions. They continued their lives trying to be as the majority of other people. They tried to

balance their lives by doing daily routines themselves and seeking a suitable employment. Some survivors showed a strong desire for full recovery. Prasom (pair 11), for instance, planned to return to his work within the next six months. Prasom said, “If I can walk well, I will get back to my job” (line 52). He seemed to have very high confidence in his ability. It persuaded him to practise walking everyday in order to prepare himself for returning to his work in Bangkok.

It became apparent that the illness trajectory of stroke from other stroke survivors contributed to some participants’ decision as to where they were, what they wanted and what they should do further. An example is Mena’s experiences (pair 12). She spoke of her realisation that she would continue life with her health condition. Mena said:

> I watched from television programmes, there are many people had a stroke, but no one got complete recovery from the illness...Some older people also had a stroke, but finally they died (line 129-130).

Mena thought that it is impossible to make a full recovery from stroke, and she already accepted her stroke-related impairments. Other examples illustrate the influence of life experience on stroke survivors’ decision-making as follows:

> My uncle has had a stroke like me for five years. He can walk and move his body. His hand became normal in the beginning of the sixth year. Now, he can walk in a straight line. I think that I have had a stroke for around two years. It is good enough to be able to walk like this (Sumet, line 269-270).

> It is the same...I am not embarrassed anymore. Other people cannot walk. I cannot walk either (Somsri, line 141).

Here Sumet and Somsri referred to their experience with other people who had a stroke. Sumet had expectations for returning to a full recovery when his walking ability was compared with his uncle. For Somsri, the words ‘cannot walk’ were used in a sense of cannot walk as usual and/or cannot have body movements like they were before a stroke. She also understood her health situation. It was shown that personal experience became part of her thinking processes affecting the acceptance of the present situation and expression of her behaviour and emotions.

The length of time that a stroke has lasted and the continuation of living under the physical limitations might affect many aspects of stroke survivors' lives. Hop et al. (2001) reported that in the initial two years post an aneurismal subarachnoid hemorrhage (SAH), there was a tendency for improving functional outcome and quality of life among the survivors. It is similar to a recent study. Greebe et al. (2010) found that around one third of the survivors with SAH who were admitted to a nursing home could do routine activities themselves within the first two years. Stroke survivors with a long experience of living under stable health conditions have more familiarity with their own ability than the survivors who have had a stroke for a shorter period. It demonstrates a similarity with my findings. Two participants, Samart and Karun, who had a period of nine and ten months post-hemorrhagic stroke indicated their health status was unstable. It is possible that improvement in functional outcomes of these participants might not regain full movement. However, they may come to accept their condition as stable and adjust their thinking pattern and practices in everyday living.

In summary, the way all participants thought and made a judgment depended on their personal experience and situation. I could say that the attitude towards themselves depended on what they thought about their life situation and how much their circumstances affected them. It could be divided into two main factors: internal and external. The former referred to the base of private self which relates to what individuals were in everyday life. The latter was involved with the individuals' life experience, carer's behaviour and the influence of social and cultural-norms, and people surrounding them. These factors may develop and create stroke survivors' self-concept. This implies that the essence of everyday living shaped the accounts of stroke survivors.

6.5 Stroke survivors' attitude towards carers

Stroke survivors' attitude towards carers is identified as a subtheme. It concerns feelings stroke survivors had about carers and how the survivors responded to those feelings. The findings relate to stroke survivors' experiences of carers' behaviour

during their everyday routine living. This subtheme was the direct result of how stroke survivors felt about receiving help from carers. Their descriptions of the quality of their feelings could be summed up as deep feelings for carers which may influence the way stroke survivors behaved and expressed their emotions towards carers, both in their presence and absence.

This subtheme focuses on two categories of stroke survivors' attitudes towards carers consisting of a good carer and gratitude to carers. The first category describes what stroke survivors thought of all the help carers gave them and how they viewed carers as a good person. This category also touches on what the survivors needed from carers. The second category seeks to explain the survivors' feelings of gratitude to their carer. As there is a connection between the two categories, some issues might be addressed in more than one section in order to understand how stroke survivors' feelings were constructed.

6.5.1 A good carer

The following discussion on 'a good carer' presents how stroke survivors valued the quality of his/her carer. One of the main topics raised was how their carers were helpful to each of them, during talking about the relationship between stroke survivors and carers. Although all stroke survivors still concentrated their attention on improvement of their physical abilities as discussed in the first subtheme, all of them stated firmly that they received massive help from carers throughout their illness. From the stoke survivors' perspectives, the most important person in their lives was their carer, and how that care facilitated daily living. Examples of individual perspectives are shown as follows:

> He (her husband) is important to me. He looks after and supports me to continue to live every day (Somsri, line 32).

> I will have many more difficulties in my life if I do not have her help. Everything is so difficult to deal with because I can do nothing...She (his wife) does both taking care of me and earning a living for the family. She does not have any day off. Our granddaughter is also in school age (Sumet, line 87-88).

> He (her husband) is hugely significant. How could I live? if I do not have him. He is the one who pays for me the cost of living. I am like this (pointing to the left side of her body). How can I work? (Mena, line 137)

In the above excerpts, the role of carer appears to be valued highly by the stroke survivors in their lives. Indeed, the data gave substance to the significance of the carers who helped the survivors to maintain the everyday running of individualised routine activities through close interpersonal contact. It is clear that stroke survivors believed that they could not continue living without carers' support. The following excerpt presents a female survivor's idea that she valued her carer as her life:

> If I do not have him, I will prefer death. He is a very nice son so he is really meaningful to me (Duangjai, line 77).

Within the study findings stroke survivors gave their perspective on how carers helped them to handle daily routines. All stroke survivors received physical support from carers. This support refers to the assistance they required in doing their daily routines and rehabilitation activities. For examples, Kamol (pair 10) said: "She (his sister) looks after me. She cooks food and washes clothes for me" (line 73). Pichai (pair 2) said that his wife always massaged his right arm and leg weakness. Samart (pair 4) similarly spoke about his wife who applied holy oil to his skin around his left arm and leg and rubbed them every day. Some survivors gave details of the personal care which involved assisting in everyday routines, e.g. bathing, dressing, toileting, feeding; and further examples are assisting with walks and exercises, building a rail for walking practice, and adapting a pulley for exercise to stimulate weak muscles.

Some stroke survivors claimed that carers provided mental support for them. This support touches on the way carers provided encouragement for the survivors both directly and indirectly. The direct way relates to how carers gave stroke survivors confidence to improve their physical ability. Stroke survivors claimed that carers talked and acted in a way that persuaded them to have hope in becoming healthier. This is demonstrated through Prasit (pair 3). Due to excess alcohol consumption Prasit quarrelled with his wife for a few months post stroke. She continued to care for him during this time and tried to encourage alcohol reduction. She also gave him

many reasons why he should quit drinking. By doing so she encouraged him to focus on how he could best live. He decided to stop drinking and developed his physical-movement skills until he could walk well and worked on the rice farm.

Indirect encouragement refers to how carers acted that affected stroke survivors' ability to think positively about their lives. Karun (pair 5), for example, called his wife 'the trusting' because she had never harmed him. She also made him feel inspired to practise walking and continue living effectively. Another example is Duangjai (pair 8). She said with a smile:

> He (her son) has never made me upset. He always talks to me softly. He may think that I am sad (line 41)...He serves and buys me whatever I want. He is my morale (line 49-50).

Emotional support from carers was also reported by most stroke survivors. This support focuses on how carers positively influence stroke survivors' emotions. Somsri (pair 1) said: "He (her husband) comes to see me many times a day if he works not far from here...I am happy with that" (line 125). Similarly, Pichai (pair 2) felt joyful when his wife said and did funny things for him. Karun (pair 5) felt safe when his wife stayed at home and talked gently to him. Furthermore, positive emotions, i.e. hope, inspiration, amusement, gratitude and love were reported by some stroke survivors (Umpa, Duangjai, Sumet, Kamol and Prasom).

Carers appeared to provide social support for stroke survivors. A person who was very close to stroke survivors was their carer. Therefore, no matter how carers behaved towards stroke survivors, it would influence the survivors' feelings, emotions and behaviour, as Samart (pair 4) described what he wanted from his wife and son, who appeared to be his social support:

> I want her to talk to me. I also want my son to talk to me, but he doesn't come to talk...I tried to beg him to have a conversation. He did not come to me (crying) (line 80).

There are two clear examples demonstrating how carers may be instrumental in opening opportunities for socialising. Pichai (pair 2) assisted his wife working in a

cornfield which he came into contact with other people. Karun (pair 5) continued working on his funded project in the community through writing assistance from his wife, in order to maintain his connection with other community leaders.

Eleven of twelve stroke survivors received financial support from carers. This support involved money and activities relating to spending. The majority of survivors stated that carers were the main person for earning money. Before being able to help themselves, the survivors received this support from carers through the provision of food, and purchase of remedies and other treatments except medication and treatment from government hospitals. After some survivors got better and were able to travel independently, carers then gave them a little money for recreation. For example, Duangjai (pair 8) said, "If I want something, my son will buy it for me straightaway" (line 38). Sumet (pair 9) bought a lottery ticket every month from his wife's money as he hoped to win the lottery. Kamol (pair 10) said that he spent money that his sister gave him, sometimes to buy a snack at a local shop, a twenty minute walk from his house. All of them expressed enjoyment in these activities. Although some survivors (Pichai, Umpa, Nisa and Prasit as described in the section on being stable with physical limitations) claimed that they did paid work, they still needed financial support from carers because that work was not sufficient for making a living.

It is clear that carers are a great support to stroke survivors. The support was acknowledged by stroke survivors as essential in ensuring effective activities of daily living. This support also contributed to stroke survivors' feelings towards carers. The role of carers continued to be regarded as vital to stroke survivors and an integral part of the nature of everyday life post stroke. It was interesting to explore how stroke survivors valued carers' input. This enabled an understanding of the expectations stroke survivors place on carers and of the role the carers undertake. This became evident across observation, interview data and field notes.

All stroke survivors stated that they had a good carer. The word 'good' was defined as having advantages and/or receiving necessary help from carers. In the sense of the term 'a good carer', there are two noticeable points in relation to the feeling of

gratitude to carers and the amount of support from carers as described earlier. The first point appeared to occur to all survivors at the time they had someone to be his/her main carer and continued to be apparent. This issue will be discussed in a further section (gratitude to carers). The second point describes the differentiation between hierarchical levels of carers' support which ranged from having basic (ordinary) support to having impressive (extraordinary) support. This meant that all survivors viewed their carer as a good person as shown by the gratitude for their support to them. The following describes the two hierarchical levels of carers' support.

The first level, which I refer to as basic support, incorporates physical and financial assistance. This 'basic support' appeared to be an initial requirement for stroke survivors in the recovery stage of a stroke. Receiving both kinds of basic support was seen to fulfil the definition of a 'good carer'. However, this level of care might not meet the stroke survivors' needs for a satisfactory life. Thus, this implies that 'basic support' simply served to allow the survivors means to maintain a basic standard of quality of life. Furthermore, it was noted that basic support was not sufficient for survivors to improve their quality of life, but mental, emotional and social support were also necessary.

Four stroke survivors in point (Nisa, Sumet, Samart and Umpa,) described a lot of physical help given to them by their carers. Their good carers were described through their hidden feelings. Nisa (pair 7) said, "I feel lonely" (line 51). She described feelings of loneliness from her husband working outside all day, and the effect on their relationship was negative. Similarly, Sumet (pair 9) said:

> I put myself in her shoes (line 39)...I am very tense because I used to be a family leader. I cannot work any more so I have to transfer a heavy load to her (his wife) (line 42)...I must help myself as much as I can. It is in order to lighten a heavy burden to her (line 106).

In the above excerpt, Sumet raised the issue of being modest with the implication that he did not want to call for something else from his wife beyond what she provided him with because he accepted his status in the family.

Samart (pair 4) thought that his wife ignored him and felt bored talking to him because he did not follow her suggestions. He said:

> I need the encouragement from her (his wife). I need her to stay with me and talk to me (tears in his eyes). It is nothing. I know that she goes out to talk to someone else (line 228-229).

This excerpt highlighted that Samart felt as if he was living alone and really needed her attention. Similarly, Umpa (pair 6) echoed the feeling of loneliness:

> I think that my mother loves my younger sister more than me...I want her to understand me (sighing). I want her to encourage me. I feel neglected (line 173-174).

The second hierarchical level of support refers to the achievement of support beyond expectations, namely impressive (or extraordinary) support. It involves mental, emotional and social support from carers. Some stroke survivors described how the support that they received was higher than their expectations. Duangjai (pair 8) said while smiling that her son took care of her very well. She thought that she was lucky because her son had never given her any cause for unpleasant feelings. The word 'happy' was used when she talked about her feelings regarding what the carer had done for her. The account presented here points to the feelings of happiness which occurred as a result of three aspects. Firstly, care and attention from her son exceeding Duangjai's expectations caused pleasant and strongly positive feelings. Secondly, she accepted her current life situation. Thirdly, from her personal experience of other cases, Duangjai considered herself not as badly off as other stroke survivors. This enabled her to view her situation positively.

The situation is similar for Prasit (pair 3). He received very good care and attention from his wife. He said:

> Very important, without her I would never have had such a positive recovery. She is taking a very good care of me (line 65).

The encouragement from his wife provided him with the inspiration for living life effectively. Prasit also described the way of his thinking:

> It was because I have got a lot of support from my wife (line 23)...Sometimes, I envy elderly people. Like my old neighbour, she wakes up early every morning and does the housework herself. She can do it much better than me. It makes me think I must do that too (line 49-51)...I try to remind myself that I still have arms and legs, even though they are not working properly, it is better than having none (line 53-55).

Duangjai's and Prasit's accounts represent those participants who received impressive support from his/her carer. Such support was impossible to see, but it could be touched through stroke survivors' feelings. It also creates an almost invisible bond that the carers developed with the survivors and within the survivors' mind. The power of these carers' support can foster and inspire survivors to improve their quality of life. Because of the difficulty of requesting or expecting such support directly from carers, it would be advantageous for stroke survivors if carers could provide impressive support for them.

This category has illustrated accounts of stroke survivors' thoughts on what carers and the carers' support were for them. The accounts highlight two main issues. Firstly, all participants viewed his/her carer role as the most important indicator towards their quality of life, although some participants reported unpleasant relationships between themselves and carers. They appeared not to be able to continue their lives without carers. Secondly, it is about how participants identified his/her carer as a good carer. At first it was noted that stroke survivors must have the feeling of gratitude towards carers. This feeling was described as an essential feeling by survivors. Retaining this feeling was related to the inherent needs of stroke survivors. Integral to the words 'a good carer' are hierarchical meanings. At the first level, the basic requirement of being a good carer was that stroke survivors received physical and financial support from carers, and this level was as much as was necessary for the definition of the good carer. The second level would be sufficient for good quality of life for all survivors as carers would be providing mental, emotional and social support.

6.5.2 Gratitude to carers

The feeling of being grateful to carers serves as a second category in the subtheme of attitude towards carers. This category relates closely to the previous sections as it appears to be the fundamental thinking which influenced how stroke survivors identify 'a good carer'. The content of this category contained two ideas from stroke survivors in relation to their gratitude. Firstly, the word 'good' raised by stroke survivors was a way to express thanks to his/her carer, and it was not controlled by the background relationship between them. The second idea is about how survivors demonstrated other feelings which related to the gratitude towards carers.

All participants reported that they became completely dependent on carers in the early stage of a stroke due to paralysis. However, after improvements in body functions, stroke survivors still received more or less sufficient support from carers. The following excerpt is an example to understand the occurrence of feeling gratitude in a stroke survivor's mind whether the relationship between stroke survivors and carers was in good shape or not. Nisa (pair 7) reported that she had had a bad relationship with her husband both before and after she had a stroke:

> The same person is the same behaviour...When I was unable to help myself, he took care of me. When I could help myself, he became the same, ignoring me... I felt good at that time when he helped me everything...It was because he had never done like that before. I then thought that he might change to a good man for me (line 197-200).

These statements reflect a general feeling which links how a person feels towards someone who does a good thing for them. This idea is compatible with Nisa who experienced a good feeling regarding her husband during the period of being unable to move the left side of her body. Although that period was short and her husband had already returned to his previous behaviour, ignoring her, she still recollected when he used to do good things for her. It was embedded in her mind and sufficient for her to express gratitude to her husband. Similarly, Sumet (pair 9) felt grateful to his wife for all the help she gave him in spite of having an unpleasant relationship between them. Although Sumet had never said that he felt grateful to his wife, it does

not mean that he did not feel it. He showed his gratitude to his wife through the way he talked about her showing appreciation of what she did for him.

Similar to Sumet, the feeling of being grateful to carers of other male participants is discovered through the content of their interviews and the body language they displayed. Pichai (pair 2) who always physically abused his wife after drinking said with a furrowed brow, "I feel sympathy for her (his wife)" (line 37). His behaviour appeared to convey the feeling of guilt for his previous behaviour to his wife. It is the same for Karun (pair 5). Karun described with sadness in his eyes:

> Before I had a stroke, I spent a lot of time with my friends drinking. Sometimes I would stay at my friends' home for a week. At that time, I had never ever cared about her (his wife) (line 192).

Here Karun's feelings indicate guilt in that he was not able to provide care and attention towards his wife, unlike his wife who took care of him very well. The following is a further example of a male participant who revealed his feelings for his carer:

> We are still the same. She helps me do everything I cannot do (line 30)...My wife mainly stayed at home to look after our son and to do housework, and I normally worked in construction. After the stroke event, she goes out to work as a construction labourer, while I am at home to do housework instead (line 126-127)...I feel sympathy for her. She is a woman who works like a man. It is hard toil. Normally, I work as a technician whereas she is a labourer. The labourer works harder than the technician. I worry about her to do hard work. I feel sorry for her. She has never been out to work without me (line 131-134)...If I cannot walk, I will become burdensome to her (Prasit, line 138).

As described above, Prasit (pair 3) realised that his wife had done well for him since he had had a stroke. He responded to those good things by trying to decrease the burden on her. He practised walking and ploughing in order to be able to work on his rice farm. He tried to inspire himself by thinking positively in every situation in his life. He also did housework although he had never done it before.

Although identifying carers as a good carer is the main method to show stroke survivors' feeling of gratitude, in my findings, each participant behaved in various

ways. For example, Mena (pair 12) gave her husband authority to do whatever he wanted. She accepted the ways he did both his works and more personal matters. Mena said: “Let him decide everything alone. I don’t mind what he does” (line 138). Similarly, Somsri (pair 1) did not meddle in her husband’s activities including in the event of an affair with another woman:

> I have never argued with him (her husband). I did not get angry at him. I also said nothing about his behaviour (line 229).

Furthermore, some participants were considerate of carers’ feelings because of their gratitude. Kamol (pair 10) accepted grumbles from his sister despite having nothing to do with him. Kamol said:

> When she (his older sister) cannot find something in the house, she always complains to me. She said that I do not help her to tidy the house...I am silent. Let her complain (line 56-57).

This excerpt reveals a characteristic pattern of managing unpleasant feelings which emerged throughout Kamol’s thoughts. It appears that Kamol was dissatisfied with his sister’s complaints because he did not do anything like his sister said. He decided to stay silent in order to avoid conflict which might arise between them. The other possible reasons as to why he chose to stop this situation by giving her a silent response instead of an explanation were supported by two points. The first point is that he felt indebted to his sister for all her help. It seems that he tried to express his gratitude to her in order to decrease problems in the house by not adding to them. It was because he knew his sister very well. If he responded that he disagreed with her, a quarrel would begin between them. The second point is that he still needed some help from his sister. He tried to make her satisfied with his behaviour as much as he could. Therefore, he let her do whatever she wanted to do with him. However, it appears that Kamol lived under some emotional pressure, and he always suppressed his feelings in front of his sister, although he still appreciated her.

In a similar way, Umpa (pair 6) had feelings of being indebted to, and of guilt about her mother. The first feeling occurred when she separated from her husband. She

came back to the care of her mother who provided her accommodation, money and other support. That is why she really appreciated all the help her mother gave her. The latter was the feeling of guilt. Umpa said: “I feel bad. Normally, I have to take care of parents, but my mother looks after me instead...It should not be like this” (line 89-90). Because of these feelings, Umpa would never dare make her mother face some disturbance although she felt tense with suppressing her feelings. Umpa described:

> My adolescent younger sister always makes me get into a mess...My mother has never listened to me about this. I then get back to my room and cry...I just felt neglected (line 91-93).

Prasom (pair 11) also had the feeling of guilt about his mother, but he expressed his feeling in a different way. Prasom said, “I do not let her do everything for me. I think that she is not my servant” (line 85). He was embarrassed to let his mother serve him in everything. He decided to show his feeling of needing to do it by himself. Prasom said: “I always tell her not to serve me. I will do it myself. I just say like this. For example, when she was going to do something for me, I told her to stop doing that” (line 84). The following excerpt illustrates his consideration for his mother’s feelings.

> I tell her that I will let her know when I need some help. It seems to tell her not to annoy or bother me. If I say those words, it will be rude to her (line 88)...I just try to say no when she tries to do something for me (line 90).

Prasom was still the family leader. His parents and children received financial support from him, and his income was sufficient for supporting his family, as he received monthly payments from his employer and from the Department of Public Welfare in compensation. However, the way Prasom acted towards his mother suggests that he felt guilty and still felt gratitude to her, although he did not feel dependent on his mother.

In summary, having gratitude to carers has mainly influenced the way stroke survivors define the words ‘a good carer’. This feeling seemed to be independent of the quality of the relationship between the survivors and carers. All stroke survivors

presented the feeling of appreciation for what carers did for them. Most male participants showed the feeling of gratitude to carers, whereas female participants seemed to be meek. However, each participant had their own method to express their gratitude to the carers. These feelings also affected how stroke survivors behaved. It is a source contributing to the suppression and management of their feelings in front of carers as well.

6.6 Conclusion

In this chapter, the data demonstrate four issues regarding various aspects of stroke survivors' accounts of their beliefs. The first issue is stroke survivors' experiences during the early stage of stroke. It provides understanding of how their lives were adapted to the effects of stroke. The second issue is the opinions as to the origin of their stroke and how their opinions were underpinned by Buddhist beliefs. The third issue is their estimation of their own ability. It expresses stroke survivors' feelings about confidence in their own power. A stroke became a burden for stroke survivors when it was weighed down by all the problems of their physical impairment, whereas it became an inspiration when the survivors valued the continuation of their lives over their limitations. The final issue is their opinions regarding the importance of carers and how stroke survivors evaluated his/her carer as a good person. The recovery from physical limitations was reported as the most important aspect of stroke survivors' needs. The role of a carer had been crucial to an improvement in the survivors' physical ability and the consequent quality of their lives. The feeling of gratitude to carers was described, independent from the quality of their relationships.

Cultural influence and Buddhist doctrines were apparent in the presentation of how stroke survivors' thought was governed by these beliefs. These beliefs underpin key issues around their feelings about their stroke, and are fundamental to how they make sense of their everyday world. The beliefs are linked very closely with Thai culture and Buddhist teachings, and influence the ways stroke survivors thought, behaved and managed their feelings and emotions in their daily lives.

The importance of stroke survivors' beliefs was confirmed in the use of reflection and storytelling to describe the process of thinking about a stroke. These beliefs appeared to be immersed in the routine thinking of stroke survivors' everyday lives. The beliefs were regarded as the fundamental principle to support stroke survivors' ideas. However, the structure of stroke survivors' beliefs was identified here as a representation of Thai stroke survivors in relation to the feelings and opinions on personal matters of their life experiences of a stroke. It is important to understand the basic ideas which are embedded in the survivors' minds and to consider the relationship between the ideas and their behaviour. When these ideas are seen as though they have occupied and ruled stroke survivors' thoughts, emotions and feelings, the behaviour is described as contributions from the influence of the ideas.

The following chapter will discuss and examine informal carers' accounting for their care of stroke survivors.

Chapter 7

Accounting for Care:
The Carer's Role in Caring for Stroke Survivors

7.1 Introduction

In this chapter I present my findings relating to how the carers account for their care of stroke survivors. The ways in which they account for their care of stroke survivors emerged as a major theme. The accounts illustrated carers' understanding and sense making of their role in the context of care and carers' experiences of care for stroke survivors. The theme consisted of three subthemes (becoming a main carer, carers' attitudes towards stroke survivors' health and the influence of neighbours) (see also Figure 4.1, p. 89). The subthemes identified the thoughts and feelings of carers based on duty in connection with their personal beliefs regarding care of stroke survivors.

The findings relate to routine situations where carers and stroke survivors continue living at home, and the carers' strategies for dealing with emotional difficulties in any given situation. From an ethnomethodological perspective, how carers understood the meanings of everyday situations refers to the nature of indexicality. The process of accounting for those meanings is involved with its reflexive nature (Garfinkel 1967). Therefore, the carers' accounts can be explained by understanding their circumstances and personal beliefs and by reflecting the way they thought and felt about their life situations.

Data extracts are reported predominantly from individual interviews. Observational data and field notes are included in presenting the results of the main findings. The word 'participants' in this chapter refers to carers. Participants' names have been altered for purposes of anonymity. The numbers assigned to each pair have been identified for the purposes of making a link between carers and stroke survivors (see Chapter 5). The current chapter is structured according to the three subthemes described above. The first subtheme focuses on why participants decided to be the

main carer of the stroke survivor and on how their lives changed after taking on the caring role. The second subtheme is about the evaluation of stroke survivors' ability from the carers' perspectives which might influence carers' feelings. The last subtheme seeks to explore how neighbours affect carers' accounts.

7.2 Becoming a main carer

This subtheme illustrates important dimensions of reasoning processes and accounting practices contained within carers' accounting for their care of stroke survivors. The subtheme is based chiefly on three categories. The first category refers to a sense of duty which revealed the main reasons and circumstances behind participants' decision to be a main carer of a stroke survivor. The last two categories are the influence of ethical practices and reciprocating kindness which emerged to explain how family values were so much a part of the feeling rules that they (family values) shaped the carers' emotions and feelings associated with their caring role.

7.2.1 A sense of duty

The sudden onset of a stroke and the consequent physical disabilities affects carers' lives (Charnsri 2008; O'Connell et al. 2001). All participants emphasised across interviews that they could not avoid becoming a main carer. They took this role after making judgments based on practical facts. For the majority of participants, three male and five female carers, the main carer was a spouse. For two participants the main carer was a mother, and the remainder were a son and an older sister. As Pound et al. (1999) points out, a major resource for supporting people living at home with stroke is their families. Most informal carers are survivors' spouses, who are involved automatically in the trajectory of stroke (Draper and Brocklehurst 2007; Larson et al. 2005; Mant et al. 2000; McCullagh et al. 2005).

In my findings, all spouses accepted full responsibility for taking the role of a stroke carer. They described the situation regarding why they took the caring role. For example, Somsong (pair 3) explained:

> There is no one. He (her husband) has a younger brother, but he just visits by sometimes. His mom and dad live in Paknampho (an hour driving from Somsong's home) and visit by like his brother. I am the only person who really looks after him…Who is going to take care of him if I could not do this? (line 16-17)

Pranee (pair 5) raised a similar issue that she was the only person who was appropriate for this role:

> I have nobody. My older sister stays with us, but she can't look after him (Pranee's husband) because she is too old (line 11)…We have a son, seventeen years old. He ignores me when I tell him to take care of his father (line 108).

It appears that caring for their husbands was also marked by their wifely duties as Supa (pair 2) said, "There is nobody to take care of him (Supa's husband) at home. My daughters had to go to school at that time" (line 49).

For male spouses of women with stroke, taking care of their wife became their responsibility. For example, Thawon (pair 12) gave a rational explanation, "What can I do? We live together. How can I neglect my wife?" (line 40) Somchat (pair 1) who had taken the caring role for nine years added new insight about taking care of his wife in his everyday life:

> I have to adapt myself to a new role because my daughter isn't old enough and my son cannot care for his mother. I am her husband. So, I must be the main carer (line 20)…We have lived together more than 20 years…My wife isn't pretending, and I must take care of her every day. It is my life. There is no one to look after her except me (line 52).

Data show that there were two of twelve carers expressing negative sentiments, Prakit and Wipa. Prakit (pair 7) took the role of carer because he wanted to appease her siblings so that they always did well by him. He has provided support for his wife for two years. It was noticed during the observation period that he seemed unwilling to help his wife, and he always ignored her. Prakit and his wife did not speak any words to each other throughout the whole period of observation. A large distance between him and his wife existed, possibly due to conflict between them. The emotions of being sad, disappointed and unpleasantness appeared on his face, eyes,

and by the tone of voice and body language used during interviews. The word 'burden' represented his responsibility as main carer. He appeared to be confronted by difficult emotions when he interacted with his wife as per the excerpts below:

> She (his wife) becomes hard work for me. It is my duty. I cannot give it to somebody else. They are their own responsibility. I have to look after her by myself (line 15)…At that time, she is unable to move. I must accept her as my duty (line 35)…My marital life with my wife always is in difficulties. I am very unhappy (crying) (line 137)…I would like to hear pleasant words from her. I would like her to show concern for me sometimes. She gives me nothing (sighing) (line 141).

The following excerpts demonstrate what Wipa (pair 9) thought about her life situation and taking on the role of main carer for her husband:

> His siblings and some of the neighbours told me that he used to send me money when he was healthy, and I should look after him in return as he is now unable to work (line 83)…I worried about him. Sometimes, he used to hurt my feelings, but I know deep down that I must take responsibility for him (line 90)…In the early period following his discharge from hospital, he was uninterested in me even though I looked after and helped him with everything as much as I could. My feeling has changed since then. I do not pay much attention to him. We still live together. It is not a husband-wife relationship anymore. He is not a person whom I can talk to like a friend, but he seems like a person who stays with me in the same house (line 106-108).

In Wipa's words, she defined what events developed over the period of time as 'the trajectory of a burden'. Her reasons may come from past experience when her husband had an affair. After the stroke event, she seemed to be willing to take care of her husband with love. She was deeply disappointed because she felt that her husband did not love her, and she did not receive any attention from him. This produced the leading causes of her unpleasant feelings. However, there was no other option than to be the main carer. Being a main carer was a sensitive thing to do for her husband.

It is clear that Prakit and Wipa maintained their role as main carers with frustration resulting from two aspects. Firstly, they were unable to change their situations, and they could not refuse to accept that taking care of their spouses was their

responsibility. It appears to be their practical reasoning which they judged morally on how they should do the right thing as a sense of duty regarding Buddhist doctrines and Thai norms as discussed in Chapter 2 (Jullamate et al. 2006; Vongvipanond 1994). Secondly, Prakit and Wipa had the expectation of becoming more important for their spouses. It caused emotional pain to them, when they failed to satisfy their hopes. They tried to protect their feelings by changing behaviour in order to show that they did not take any notice of how their spouses behaved. It was like a shield against the pain of disappointment.

For Prakit and Wipa, an unpleasant relationship between them and their spouses may have an effect on the way they thought and behaved as though burdened when they interacted with their spouses. Their experiences of role changes after the stroke event appear to be developed and changed over time. A change is "a dynamic process that is sensitive to temporary and enduring contextual cues" (Pietromonaco et al. 2002: 25). Taking on caring roles and responsibilities may lead to a change in their relationship. Several studies have revealed that a negative impact on the marital relationship between stroke survivors and their spouses tends to occur while living at home (Bäckström et al. 2010; Bäckström and Sundin 2010; DeLaune and Brown 2001). However, it was evident that the impact on the relationship is not always negative (Gillespie and Campbell 2011). For example, Supa (pair 2) and Pranee (pair 5) reported that their relationship with stroke survivors had improved since the stroke event. It is shown that the marital relationship was changed not only by the effects of stroke, but also from the effects of how they thought and felt about having their marital lives adapted to the changing situation.

The remaining stroke carers were two mothers, a son and an older sister. They became carers for various reasons. For the mothers, they took the role of a main carer because of the mother-child relationship. Naree (pair 6) assisted her son-in-law with care of her 25-year old daughter who had a stroke and also took care of a granddaughter who was born while her mother was admitted to hospital with the stroke. At that time, her daughter lost her job, and then her marriage broke down six months after the stroke event. Naree had been thrown into the caring role since then.

Somjai (pair 11) was a parent carer who took care of her son. It was because her son separated from his wife around five months before having the stroke, and their daughter and son were too young to care for him. Although he had an older sister, she had her own family and job in Bangkok (three hours driving to Somjai's home). Therefore, Somjai was the only person who was suitable to be his main carer.

Pracha (pair 8) was the right person for taking care of his mother who had had a stroke for five years, and he was willing to take this role. The family situation provided the explanation for why he became a main carer. There were four people in his family, his father, mother, older sister and him. His father and sister had their own jobs with good salaries. At that time, Pracha was looking for a job after his graduation which coincided with an early stage of his mother's illness. Another reason was that he was familiar with his mother and knew her very well. He always took care of her during her previous admissions to hospital. It can be said that his role was established implicitly for this stroke event.

Usa (pair 10) was willing to take care of her youngest brother in order to keep a commitment to her parents that she would support her siblings, who had personal problems, as much as possible. When her brother had a stroke and experienced marital breakdown, loss of work, and financial difficulties, she did not hesitate to take all responsibilities and the role of a main carer for her brother.

The carers' work seemed like a responsibility added to everyday activities that people had in given situations. There are a large volume of published studies describing various roles of informal carers who serve stroke survivors at home. The carers are as a provider who gives necessary things to stroke survivors for living, such as food, clothing, money, a residence and medicines; as an assistant who helps survivors with daily routines, such as bathing, exercising and toileting; as a supporter who encourages survivors with rehabilitation and prevents them from developing complications; as a coordinator who works and communicates between survivors and other people, such as doctors, health officers, family members, siblings, relatives, and friends; as an organiser who plans and arranges for survivors to have a safe

environment and convenience; and as a mind-protector who provides mental, emotional and social support for survivors (DeLaune and Brown 2001; Harris at al. 2010; Hinojosa et al. 2009a; Hinojosa et al. 2009b; Lee and Mok 2010; McPherson et al. 2011; Meesuk 2005; Prawtaku 2006; Visser-Meily et al. 2006).

In the course of the explanation of my findings above, all carers showed an ability to react to situational changes in their lives. They identified the caring role as a common duty governed by morality influenced by Buddhist values (see section 2.4, p. 39-46) and the basic level of their own judgment in a reasonable way. They agreed to take the role of an informal carer such that the planning of care activities became immersed in the habitual practice of their daily routine. Furthermore, the personal narratives referred to some details of what cultural values were transformed into everyday life events of individuals relating to social life. These existing stories may be influenced by an individual's reasoning process, attitude to life, interpersonal relationships, circumstances and situations in life.

7.2.2 The influence of ethical practices

One of the most important cultural influences on Thai families is Buddhist religious beliefs which are very close to Thai people's minds (Cook 2010; Pinyuchon and Gray 1997). Buddhism has emerged as a principal philosophy for Thai society and affects the way of life among Thais (Christopher et al. 2009; Kongsuwan et al. 2012; Limanonda 1995; Lundberg and Thrakul 2012). The ideas of ethical practices from the teachings of Buddhism are involved in Thai Buddhist thinking processes which may play a part in a decision to take care of stroke survivors among Thai carers. For example:

> I think that it is my karma. I might have done a bad thing to him before. Now, he returns the bad thing to me. I always do good things to him. I cannot abandon him. I don't know when my karma is totally ended (Supa, line 392-393).

The discourse above illustrates a sense of understanding the meaning of karma in Thai Buddhist beliefs. There were two aspects in relation to the strong belief in the law of karma. Firstly, Supa (pair 2) accepted her karma in the current life situation as receiving a punishment. She believed that she had done some bad things to her husband in her previous lives, so the bad things occurred in her current life in return. She was willing to receive the result, although she did not exactly know what she did in her previous lives. This idea suggests that Supa owed her husband and must compensate for all mistakes in her previous lives. It was time to receive the return of its reflection. Secondly, she thought that providing good care for her husband was a way to do good things for promoting the happiness of her present life. The following excerpts show carers' ideas of karma in connection with the stroke event and their current life situations:

> I think that it is the result of my past actions…It has given me difficulties since I was young (Naree, line 89-90).
>
> I believe that I did bad things in a previous life...(crying) (Somjai, line 265).
>
> I follow from the sayings of my ancestors who said that it results from my actions in previous lives. In my present life, I have never done wrong with other people (Thawon, line 158-159).
>
> I think that I do good things, and good things will happen to me. I have now a lot of trouble because I might have committed a sin in my past lives, and consequently I face many problems in my present life. My children died in adolescent years. My husband has a paralytic illness (Wipa, line 265-266).

Naree (pair 6), Somjai (pair 11) and Thawon (pair 12) strongly connected the idea of having difficulty in current life with the result of their own previous lives. Similarly, Wipa (pair 9) presented awareness of doing good actions to expect a better life. The findings reveal that a religious belief in karma was relatively close to what carers thought about their caring role and way of living. Although the religious belief is not able to be seen and felt with the fingers, it appears to be a powerful influence on the way people think about their lives. This is one of the most important teachings in the Buddhist perspective; karma seems like a coping mechanism for dealing with difficult situations. It is a way of finding pleasures in human life. The idea of the past lives implies that someone should make an effort to use positive thinking to reduce

his/her suffering, while the idea of making 'Bun' (good things) and avoiding 'Bap' (bad things) may be intended to encourage someone to do morally right in order to stay out of trouble and to make a sense of peace in their lives (Egge 2002; Mokkhabalarama 1988; Payutto 1993).

The influence of ethical practices is identified as one of the main reasons contributing to carers' decision to take the role of a stroke carer. This relates to what Thai Buddhist carers thought about their lives, an aspect strongly encouraged by religious faith and spiritual belief. There appears to be a sustained effort by carers to hold the feeling of being willing to be the carers of people with stroke. The ethical practices seem like a mental anchor for the carers. It made carers accept their life situations and face the situations with a certain state of mind.

7.2.3 Reciprocating kindness

The perspective of Thai family members' relationships is necessary in understanding stroke carers in care responsibilities for the recipient. It may develop a moral obligation to reciprocate kindness (Limanonda 1995; Pinyuchon and Gray 1997). A feeling of gratitude such that carers feel indebted to stroke survivors becomes a part of influencing a close bond between them. The quality of being grateful is a rational decision in carers' account for supporting stroke survivors. In this category, the relationships between mothers and children, siblings, and spouses were presented in term of how carers made sense of feeling grateful to stroke survivors and how they chose to reciprocate a favour.

The findings show that a child expresses gratitude to his parents. Pracha (pair 8) left an opportunity to work in Bangkok after his graduation, which was a good job offer from a well known company, in order to take the caring role for his mother. At that time, he thought that his mother would get better within a few years after the stroke onset, and he could work from then on. He stopped thinking about working and focused on care work. Furthermore, the full-time carer role seemed to cause him to lose his social contacts. He had only a few friends because of not having much time

to join them, and he hardly participated in any social events because he felt guilty every time about leaving his mother at home while he went out to meet friends. This, in effect, changed his life. After five years in the caring role, he thought that there was less chance of working outside home, and he decided to continue taking care of his mother rather than transfer the role to others. His plan for working was to do something at home so he could do his job and take care of his mother at the same time. Pracha said:

> I spend my life with my family. It may be a commitment that we have to encourage each other. If we cannot help each other who can help my family in this situation? If I let my older sister quit her job and/or work at home in order to take care of our mother, I will pity her for that situation (line 111-112)…She (his mother) looked after me very well throughout my life. It may be a special bond between mother and child. It occurs naturally in my mind. I should return good things back (line 255).

The close connection joined all family members together such that each family member was important to others. For Pracha, the bond of family relationships appeared to be very powerful, and all members of his family strongly influenced his decision. He sacrificed his personal life for gratitude and maintaining a peaceful family. He showed his gratitude not only for his mother but also for his father and older sister. It was shown that all people in the family were very important for him, and he tried to pay them back with good things. Therefore, he decided to change his plan to make it suitable for his family life. It appears to me that the sense of gratitude developed in his own mind was governed by both micro and macro social functions. The former refers to family values which have originated from the strong family relationship. The latter relates to the general customs and beliefs among Thai people that make them become accustomed to the ideas of gratitude.

Similarly, many carers expressed their feelings of gratitude to stroke survivors. Somsong (pair 3) said that she owed a debt of gratitude to her husband (stroke survivor) because he had taken care of her very well for a few months after she had an abdominal operation five years ago. Mesa (pair 4) was very grateful for much help from her husband (stroke survivor). Before her husband had a stroke, she stayed at home and was a housewife, while he provided her with many things, such as money,

food and clothes. Wipa (pair 9) talked about the financial support that her husband (stroke survivor) gave her before he had the stroke. Usa (pair 10) said that her younger brother (stroke survivor) sent money to her every month. Although it was not a lot of money, she felt grateful for his kindness. Somjai (pair 11) said that she and her husband are in old age and could not earn money themselves. She could continue life because of the money from her son's salary (stroke survivor).

The findings above illustrated a matter of concern that carers felt to return what they had received from stroke survivors. It seems that the quality of being grateful took part in the influence of a willingness to be a carer in the way that they showed thanks and returned the favour to stroke survivors. This feeling may be constructed by family values, social norms and religious beliefs because most Thai people have fostered the idea of gratitude since they were young (Limanonda 1995; Pinyuchon and Gray 1997).

In summary, the subtheme: becoming a main carer focuses on what factors influenced people to decide to propel themselves into the caring role of stroke survivors. Three categories (a sense of duty, the influence of ethical practices, and reciprocating kindness) emerged as main reasons for taking on the caring role. This subtheme also discussed how the cultural and religious context influenced Thai family life and the way people thought. In social life, people have their own knowledge and rationales which contribute to their actions with regard to socio-cultural issues (de Kok 2008; Hutchby and Wooffitt 2008). For Thai stroke carers in rural areas, the belief in responsibilities for their family members and/or a moral obligation to be grateful to a benefactor made them willing to help stroke survivors' continuing lives. However, they could manage care work and merge this with daily activities, although the stroke event directly affected carers' lives. This idea may associate carers' accounts with the encouragement of how they make sense of performing emotion work in everyday life.

7.3 Carers' attitudes towards stroke survivors' health

Carers' attitudes towards stroke survivors' health are identified as a subtheme of carers' accounting for their care of stroke survivors. The focus of the data analysis remains relational in regard to the carers' perspectives on the current status of stroke survivors' health. This subtheme seeks to explain how carers evaluated stroke survivors' ability to carry out activities in everyday routines and how stroke survivors' status in the family was positioned.

Stroke survivor as a disabled person and stroke survivor as an ordinary person with physical limitations emerged as two categories of carers' attitudes towards stroke survivors' health. Preliminary issues revolved around the decisions carers made about stroke survivors' capabilities. These issues were apparent in the carers' construction of their experience as main carers of stroke survivors and the resultant relationship. The issues are linked to the quality of care provided by carers and how carers behaved and expressed their emotions and feelings towards stroke survivors when they interacted with each other.

7.3.1 Stroke survivor as a disabled person

Stroke survivors, who had some physical impairment, were deemed by carers to be a disabled person. This attitude seemed to come from carers' personal judgment relating to the comparison between stroke survivors' current (in)ability to perform activities of daily living and their ability before the stroke event. Carers noticed that stroke survivors gradually improved their physical capabilities over time. Somchat (pair 1) described the significant progress in his wife's physical power to do her routine activities. He appeared to accept that his wife had reached her personal limit regarding physical capabilities:

> At first, she was able to clean herself, and after that she could wash her clothes. Now, she can walk by herself to go somewhere she wants to go… Sometimes, she uses a walking stick to prevent slipping (lines 56, 59)…I do not expect she will completely recover from a stroke…It (stroke) has neither got better nor worse for seven to eight years (line 196-197).

Similarly, Pracha (pair 8), who took care of his mother for five years, spoke of the progression in his mother's physical movements:

> In the first two years of her stroke, she was supremely confident of making a complete recovery. Five years have already passed. I think she is much better than the early stage of the stroke (line 70)…She still uses a three-legged cane to help her walk (line 74).

Excerpts from Somchat and Pracha showed their personal experiences during the stroke survivors' recovery. They believed that stroke survivors would never make a full recovery, although they had shown signs of improvement. Therefore, the ongoing care of stroke survivors was provided by those carers. This meant that the level of care needs were partial rather than absolute, i.e. they only needed help with certain activities of daily living rather than total care. Usa (pair 10) expressed the rate of making progress in her brother's physical function:

> In the last two years, he can do some routine activities such as bathing and dressing (line 65)...I think that he (her brother) is getting better. He now has around fifty percent returned ability (line 245)...He can cook rice for me, but I don't allow him to wash the dishes because I have a feeling of not clean enough resulting from using one hand (line 247).

Usa appeared satisfied with her brother's improved bodily function for now. However, his capability was judged as too limited for performing some activities. She was also proud that her care was conducive to the progress of her brother' physical abilities:

> I have taken care of him from when he had no movement in his right side of the body to being able to do some activities himself (line 245-246).

Like Usa, some participants expressed feelings of pleasure and pride in their involvement in the stroke survivors' improvements in physical power. For example, Somchat (pair 1) referred to his contribution:

> I am satisfied with her progress (line 88)…I think it is because I am very attentive to her (his wife). I take care of her and always follow what doctors and other people suggest (line 91).

Thawon (pair 12) talked about the support he provided for his wife, and he was very happy that his wife was almost entirely the same as before the stroke. He was confident about leaving his wife alone at home during the day, while he went to work outside. However, the situation had changed in the last two years as he said: "She seems to be getting worse. She cannot do things and housework as usual" (line 91). As a result Thawon had to pay more attention to his wife's health and not allow her to go to work outside with him.

As discussed earlier, participants talked about stroke survivors' changed bodily function. The survivors were seen as becoming disabled and having less status. Pranee (pair 5) evaluated her husband's abilities post stroke:

> The movement in his left arm and leg is not well enough, but I think that it is better than being unable to move them. I can take him to the rice field. He goes to the field with me every day. He stays at a hut, while I work in the field (line 126).

Pranee seemed to have some satisfaction in her husband's existing condition. She dealt with this feeling simply, by thinking positively and trying to adapt to the new situation. Here Pranee indicates that her husband's physical limitations prevent him from doing work. Similarly, Wipa (pair 9) said:

> He (her husband) has never recovered. Two years is too long a time. I think that he might not be back to the same as before, OK, I know that he may not be in the full recovered stage…It is impossible to hope that he will be back to work (line 226-227).

From the carers' viewpoint, it is important to note that stroke survivors' being unable to work as usual was seen as having disability.

Mesa (pair 4) made a different point regarding what caused progress in stroke survivors' body functions when she described how she felt:

> He stays in the same position all the time. He only eats and lies in bed. He intends to walk when he needs to go to the toilet. I always tell him to exercise on his left hand and fingers, but he refuses. If he exercises and stretches out his left hand and fingers regularly, they will not be locked like this (curved

> position)... He complains of getting hurt when I help him to stretch his hand (line 87-89)…I do not think that he can make a full recovery from stroke because he has never done things by himself (line 124).

Here Mesa referred to an additional aspect which aids stroke survivors' recovery. She felt that the survivors' perspective should include a strong desire to help themselves in everyday activities instead of waiting for help from carers. Wipa (pair 9) described that she closely followed her husband's progress. The following excerpt showed the cause of conflict between her and her husband. She thought that he did not try to make a complete recovery:

> In the early state of a stroke, he was unable to walk. I always helped him to practise walking every morning (line 198)…Once he can help himself I just motivate him to walk. He is lazy, and he always sits and lies all day long (line 213).

Wipa gave an example of what she thought about her husband's behaviour, which increased the conflict:

> He hardly ever does housework. I know he can do most housework, but he has not done it for me. I just wonder why he does not want to help me reduce my heavy burden (line 113-114).

Wipa already placed her husband within the context of disability, and she continuously struggled to live with doing hard work and the conflict between them. It seems as though she felt his disability was at least partially self-inflicted as she saw him as lazy.

Mesa and Wipa remarked that lack of a strong desire to make recovery from stroke and laziness were additional causes hindering stroke survivors' progress. Pracha (pair 8) expressed another point of view on this issue. He said that his mother had not much confidence in her own ability to walk:

> My mother could walk properly with a cane, but she hesitated to walk because she was fearful that she might fall down. She needed me to cradle her when she wanted to go somewhere all the time (line 72)…She is weaker than before. Because of flooding for two months, she has never walked since then…She now looks as if she is not strong enough to walk (line 76-77).

Pracha's account suggests two things relevant to his mother's health post stroke. First is the different view between Pracha and his mother. He referred to the way his mother thought about her health and how this contributed to her inability to walk. He believed that his mother did not have much confidence in her own ability to walk despite having the physical power to do walking. For his mother, her view was that dependence on her son while walking provided her with a feeling of safety. Secondly, it was the current situation (severe flooding in Thailand) that influenced his mother to get weaker as she was unable to practise walking for two months. However, she was still able to walk. Pracha tried not to blame his mother for this issue and sought another reason to explain why his mother had stopped practising walking. It seemed to be a coping strategy which helped him to protect his feelings and emotions that he should not be nervous around his mother's progress.

The point in time in which the stroke survivors' progress in ability is apparent also impacts on carers. There is evidence to suggest that there is an improvement in functional outcome initially two years post stroke (Greebe et al. 2010; Hop et al. 2001). This is supported by my findings. Most carers stated that stroke survivors' physical power had been dramatically improved during the first two years post stroke, and the stroke survivors' capability appeared to remain virtually unchanged since that period of time. In my study, there were three stroke survivors who were in the period of the first two years post stroke. Their carers reported a noticeable improvement in these stroke survivors' ability. These situations may make both stroke survivors and carers accustom themselves to the changes and help them ascertain a suitable way to manage feelings and emotions towards each other.

In this category, carers described their attitude towards stroke survivors as people who had become disabled. This was based on their experiences of how stroke survivors behaved in everyday life. The abilities to work and do routine tasks appear to be the main criteria which carers used for assessing stroke survivors' disability. However, carers indicated that a successful recovery was not only as a result of the care they provided but also was determined by stroke survivors themselves. These

issues caused carers to think about what care and attention stroke survivors still needed from them.

The following category presents a contrasting attitude in which some carers saw stroke survivors as the same status as the majority of people.

7.3.2 Stroke survivor as an ordinary person with physical limitations

This category describes how carers determined that stroke survivors had returned to normal ordinary activities despite having body limitations. Three participants (Supa, Somsong and Prakit) are associated with this category. Supa (pair 2) talked about her husband's health following stroke. Supa's account will be used as an example of how carers defined the concept of normal life with physical limitations:

> I think that he has gradually recovered from the stroke. He has no other illnesses, such as diabetes and hypertension, over the last nine to ten years. He is normal (line 314-315)…He is very strong. I think he has become normal, but he is just unable to raise his right arm and leg. It is impossible that he will return to how he was before the stroke (line 345-346). He looks like a normal person. He could saw wood with one hand. Look at that (pointing to a tree stub) (line 348).

Apart from the limitation of body functions, the concept of having a normal life was brought up by Supa. Her experiences with the stability of her husband' health conditions and no complications seemed to be mainly used for defining normality as ordinary people, and the physical impairment of her husband appeared of no importance in her consideration as she said:

> Sometimes, he goes to work with me. He helps me to prepare machine tools for working in the field. I feel encouraged by his support (line 194).

Somsong (pair 3) said that her life was better now compared to the early state of the stroke. She was measuring her husband's abilities in terms of his ability to do all things the same as most people do as a normal state of affairs. For Somsong, returning to work meant that her husband was back to normal life. She considered that her husband could carry out his duty almost the same as before, doing rice

farming. She was also proud that her husband could work on the farm on an equal footing to most people. Somsong's account is demonstrated through the following excerpts:

> We work together on the rice farm. I help set up some equipment for his tractor due to the limitation of his left arm and leg. He then works in the farm all day long (line 35-36)…I would not be able to do the rice farming if I did not have him. I cannot drive the tractor, but he can. He also can irrigate fields, and I just give him a little bit help for that…I think that he is now stable. I am satisfied although he cannot walk straight like other people do (line 38-40)…He is very hard-working. Our neighbours always say that he is more industrious than people who have no limitations (line 163).

Interestingly Supa and Somsong raised a new concept of normality for stroke survivors, i.e. being highly satisfied with stroke survivors' abilities. Although these two participants appear to accept stroke survivors' bodily limitations, the quality of normality was seen to have meaning for participants beyond a completely able body. Supa related this normality to her life in general. She realised that her husband had maintained a stable health status during a long period of time. It met her expectation because she needed her husband to be comfortable with his life situation and to continue living normally. In this situation, she was willing to take the role of the family leader instead of him. On the other hand Somsong expected her husband to take on the family leader role, and this gave her a sense of security in life. It appears that normality for them was interpreted according to their expectation of the survivors.

Another example is Prakit (pair 7). He stated that his wife became healthy despite any physical difficulty she still had. He expressed what he thought about his wife's health and their family life:

> Although she (his wife) is now able to help herself, I still have a large financial burden. For her, she just takes care of herself, while I have to make more money for paying off my debt…I owed someone money for curing her from stroke two years ago, and I now pay interest 600 bath per month (line 91-93)…She is not concerned about me; how my health is; what work is going on; whether I can clear my debt. She just worries over her health (line 97)…I have run out of money. In the meantime, she becomes healthy (line 204).

Prakit's words showed a cause of conflict between him and his wife in the lack of attention each received from the other. He needed her to consider him and to involve him in her life; this situation caused an unpleasant relationship. In relation to the conflict, one could infer from the above that Prakit had a great feeling of certainty that his wife was at the stage of recovery. The state of his wife's health was moving towards independence which had been the key aim. The effect of this unpleasant relationship seemed to influence his opinion of his wife's health. For this couple, once he found that his wife was able to do things by herself and used a walking stick to help her walk, the situation indicated she had returned to a normal stage of everyday living as other ordinary people.

For this category, carers described the state of stroke survivors' health as equal in status to 'ordinary' people through the fact of being able to perform activities themselves. The definition of a stroke survivor as an ordinary person with physical limitations in this category presents taken-for-granted assumptions in everyday life based on carers' accounts. Carers' expectations are the key factor in indicating being ordinary. Carers hoped that stroke survivors could help themselves to do their daily routine and other tasks which the carers expected them to complete. Thus, the idea of normality was effective as long as it was compatible with the carers' expectation. Furthermore, the quality of the relationship between carers and stroke survivors is also important. In the unpleasant relationship, the impact of conflict might induce a carer to be inattentive to a stroke survivor.

In summary, the subtheme: carers' attitude towards stroke survivors' health concerned how carers evaluated stroke survivors' ability to carry out activities in daily life. Two contrasting ideas, stroke survivor as a disabled person and stroke survivor as an ordinary person with physical limitations, were explored. The former was carers' evaluation of how stroke survivors had limits on doing things and in consequence how the survivors did not achieve equal status to most people in local society. It influenced carers to keep providing attentive care for those stroke survivors. The latter related to how carers defined stroke survivors in the same class as the majority of people. It involved the idea of reaching carers' expectations. This

suggests that the health status of stroke survivors was focused by carers through how stroke survivors get back into their daily routines as appropriate to normal everyday living. However, the quality of relationship between carers and stroke survivors may or may not relate to carers' attitude towards stroke survivors' health.

7.4 The influence of neighbours

The influence of neighbours emerges as the third subtheme. The definition of neighbours in this study refers to people who lived near to the participants' homes whether or not they may have face-to-face interaction. The neighbours might also be close and/or distant relatives of the participants (e.g. siblings and other kin). This subtheme illustrates the power of neighbourhoods and the effects it has on carers of stroke survivors and how the effects shape the carers' accounts. The subtheme is also associated with both the characteristics of Thai rural living and the nature of local community.

The locations of participants' homes were in the same area as their parents' and relatives' homes. It is normal for Thai people in rural areas that relatives visit each other's homes. Not surprisingly, some carers reported that they received some support from siblings and/or cousins to assist in care work for stroke survivors. For example, Somchat (pair 1) described:

> In the early stage of the stroke, my wife's elder sister helped me to take care of her (his wife) (line 101)…She (his wife's elder sister) helped me reduce a heavy burden at that time (line 148)…I asked for some help from my wife's elder sister when I was unable to manage rice farming tasks (line 178).

This situation can be viewed as Somchat taking advantage of his wife's elder sister's support as a carer and with work in the rice fields to help reduce his burden. Similarly, Wipa (pair 9) described that her cousin gave her some help with carrying her husband to hospital for physical therapy. For other carers, they mentioned a considerable variety of situations in this regard:

> My husband's mother helped me to apply a compress and massage for my husband when he fainted (Supa, line 278).
>
> Sometimes, my husband's elder sister, who lives next door, came to my assistance when he (her husband) fell into a faint (Mesa, line 30).
>
> At lunch time, my aunt sometimes helped me to feed him (her brother) if she was free, otherwise I had to come back home and do it myself (Usa, line 259).
>
> My wife's niece stayed with us around one month in order to be my care assistant (line 18)...After that she (his wife's niece) often comes to help for a few days at a time (Thawon, line 138).

Excerpts presented here indicate that the support from participants' close relatives was an occasional activity. It appears that receiving practical help from relatives particularly occurs in the early months post-discharge where stroke survivors needed total care. At that time, carers paid full attention to stroke survivors' immediate lives, and the help the relatives provided for participants seems to happen as part of an ordinary course of events. However, the management of the care work still belonged to a main carer.

The perception of carers was influenced by the neighbours as they were supposed to follow social norms in particular aspects of everyday living. In the findings the neighbours were comprised of next-door and nearby neighbours. However, the participants might or might not communicate with those neighbours. Two categories that arose within this subtheme include neighbouring as a source of encouragement and as a source of social pressure on carers. These categories explored how the neighbours produced significant effects on the carers both directly and indirectly.

7.4.1 Neighbouring as a source of encouragement

Several studies have revealed that the carers of stroke survivors needed emotional and psychosocial support to maintain their own emotional well-being (Chow et al. 2007; Green and King 2009; Richardson et al. 2007). Some carers talked about the encouragement of their neighbours which provided them with the power and confidence to take care of stroke survivors. In Somsong's words (pair 3):

> They (Somsong's neighbours) tell me that my husband is very lucky for having a wife like me because I have never left him (line 31)…I feel good when I hear those words (line 188)

Somsong indicated the feeling of satisfaction at directly hearing her neighbours' praise for what she had done for her husband. According to Somsong, she faced changes in her life and her way of living in the aftermath of her husband's stroke. She had to learn to manage intense care work, for her son and husband, including doing housework and outside work. The neighbours praised Somsong for succeeding in carrying out all of this work. Usa (pair 10) who had earned admiration from neighbours for her caring role described how she responded to the admiration:

> My neighbours said that I am very good at care work, especially Nida (one of Usa's neighbours) who always said that she could not find someone who was able to look after an ill person very well like me (smiling)…It is very encouraging to provide better care for him (her brother) (line 304-305).

Usa was very proud to be compared with other people. The neighbours' admiration seemed to be an acknowledgement of the responsibility she took for her brother. She also gave an example of how a community nurse praised her for her competence in the care work she provided. The feeling of pleasure could be seen through a broad smile on her face and a cheerful tone of voice during the interview. She expressed clearly that this feeling contributed to her strong desire for taking better care of her brother.

Pracha (pair 8) touches on the same issue when he spoke of his thoughts on the influence of neighbours on his life. He said that the neighbours admired his great dedication in caring for his mother. In his words:

> Other people, who have ever seen what I have done for my mother, say that I am a very good carer and I take care of my mother very well…That is ok. I do not mind what neighbours say about me…I am often given praise when I take my mother outside. It does not mean that I do this because of people's admiration towards me (line 118-120).

Pracha stated that he did not have any interest in the neighbours' behaviour. However, he communicated a pleasant feeling at the time he talked about how his

neighbours behaved to him in the given situation. From Pracha's point of view the neighbours' admiration was not a significant factor for him to continue the caring role, but it appears to positively illustrate his accounts of how he cared for his mother.

Wipa (pair 9) took care of her husband even when there was an unpleasant relationship between them, and earned a living alone after her son passed away. She also referred to the issue of the neighbourhood influence, but slightly differently:

> A neighbour gave me a prayer book. I have prayed to Buddha since the death of my son. I pray every day (line 246)…Nowadays, I do good things, and I receive good results- there are kind people providing jobs for me. I have a lot of work (line 269).

Wipa had strong beliefs in Buddhism. It seems that following the Buddhist ways made her remain calm in difficulty and face changing situations with positive thinking. She appreciated her neighbour who advised her on a positive way to cope with her changed life situation. For her, encouragement was associated with good morals. She thought that taking care of her husband was one of the good morals that she should live, by giving it back to him, and the offer of jobs from neighbours came as a result of performing good behaviour. This situation reduced financial problems which were a large burden to Wipa. It implied that the neighbours gave positive encouragement to her and enhanced her power to continue life with her husband.

Similarly, Prakit (pair 7) believed that he got jobs from neighbours to earn money and to pay his debt because of his virtue. The virtue involved taking on the caring role for his wife. Prakit looked after his wife despite having an unpleasant relationship between them. It was because he wanted to return his gratitude to his wife's siblings. He thought that the way he behaved was in accordance with good morals. This way of living morally was confirmed by his wife's siblings and the neighbours because they praised him for taking responsibility as a main carer. The neighbours always provided him with jobs. It seems that the origin of his life encouragement for undertaking the caring role was mainly from his wife's siblings and neighbours instead of from his wife.

The cases of Wipa and Prakit showed an indirect influence of neighbours which linked to belief in the Buddhist religion. The neighbours, who provided them with work, were encouraging both the development of their personal virtue and the enhancement of their ability to continue doing care work. The poor quality of the relationship between these carers and stroke survivors appeared to affect the high level of the encouragement received from the neighbours in carers' accounts.

The neighbours were also referred to as a source of information about stroke. Eleven out of twelve carers talked about sharing information with their neighbours. For example, Supa (pair 2) got a list of herbs to make Ya-Moh from a neighbour who used to be a stroke carer. Somchat (pair 1) and Thawon (pair 12) bought Ya-Moh from local folk healers. Many neighbours recommended to Somsong (pair 3) and Pranee (pair 5) specialist stroke doctors and stroke rehabilitation clinics. Mesa (pair 4) and Pracha (pair 8) received suggestions from their neighbours, who used to be carers of stroke survivors, about home exercise equipment for the survivors. Furthermore, all eleven participants said that they received information on traditional treatment/medicine including quacks (see Chapter 5). It was evident that some information had proved ineffective in aiding recovery from stroke. However, the information from the neighbours seems to encourage hope.

Neighbours were reported by all carers as a source of admiration, praise and information. Most carers expressed the view that neighbours partly contributed to their encouragement. Moreover, the neighbours may be the main source of encouragement for carers, particularly in cases where a bad relationship existed between carers and stroke survivors. This finding implies that the neighbours were identified as one of the underlying significant factors in carers' accounts of their everyday lives. The quality of encouragement from the neighbours appeared to be related not only to the past, the experience of taking care of a stroke survivor and sharing information/experience with them, but also to the future, the continuation of undertaking the caring role and maintaining the survivors' quality of life.

7.4.2 Neighbouring as a source of social pressure on carers

The second category indicates that neighbours emerged as a source of social pressure on carers. This may enhance carers' awareness of undertaking and maintaining the caring role. As discussed in the subtheme of becoming main carer, a sense of duty, moral obligation, and the feeling of gratitude for stroke survivors were significant dimensions of the decision to take the role of stroke carer. Those dimensions showed the quality of Thai family relationships and the close bond between carers and stroke survivors.

Some carers described the involvement of the neighbours in their lives relating to having to care for stroke survivors. Mesa (pair 4) said:

> I live with him (her husband) for many years. I cannot leave him for his health reasons. Other people will talk about me in a bad way if I leave him in spite of being unable to help himself in life (line 194).

Mesa explained that she cared about the neighbours' opinion of her responsibility towards her husband during his illness. The norm of taking the caring role for the spouse of a stroke survivor became relevant as a moral value. Mesa also expressed the feeling of guilt if she acted against good morals. The data suggest that neighbours can be viewed as having control over the standard of good behaviour displayed. The neighbours' expectations influenced Mesa to comply with social norms, and a sense of realisation came into her account of accepting her role as the main carer of her husband.

Wipa (pair 9) also presented a statement from her neighbours which influenced her realisation that she must act as the main carer for her husband. Wipa said, "A neighbour stated that my husband looked after me and gave me money to live before having a stroke" (line 83). From this excerpt, Wipa could not ignore what her neighbour said because it was true that she depended on her husband completely for money before the stroke event. However, she disputed the neighbours' words in other respects:

> They (her neighbours) do not know that I faced difficult situations because of him (her husband). I had to tolerate his bad behaviour and that hurt (line 171).

Wipa had a long and unhappy marriage which was the basis of the conflict between her and her husband. The conflict became obvious in the aftermath of her husband's stroke. Excerpts above illustrate that Wipa had contrasting ideas at the same time. Firstly, she was now financially independent and did not depend on her husband at all. She worked for money and continued looking after her husband, although she still suffered from marital problems. However, it appears that what the neighbours said to Wipa contributed to her appreciation that her husband used to support her with money. The second idea was associated with her strong belief in Buddhist teaching, as mentioned in section 7.4.1. This idea seemed to be a factor which enhanced her good morals and feelings of gratitude towards her husband. She decided to follow social norms and maintain her virtue in the Buddhist sense by keeping on taking care of her husband albeit in conflict with him.

Both Mesa and Wipa described neighbours as the stimulation for realising the importance of maintaining their caring role. Furthermore, there is another point in carers' realisation aroused by neighbours. Somsong (pair 3) talked about her feeling when she received information regarding cure for stroke from her neighbours:

> I used to take my husband to Bangkok in search of a cure for stoke on the advice of a neighbour. The doctor could not make him a full recovery. I went there two times and spent more than 4,000 baht a time (line 174-175)…Another neighbour recommended good stroke doctors to me. My husband also needed to go to those doctors because he wanted to recover from the stroke. If I did not take him to doctors, he might think that I saved money for myself (line 178-179).

For Somsong, neighbours were not only a source of information, but also a stimulus to seek extra medical treatment for her husband. She took her husband to see a private doctor and spent around 4,000 baht per treatment. Somsong mentioned the financial issue because it was more than her finances would allow. From a financial point of view this placed a greater emphasis on her intention to promote her husband's full recovery. Moreover, this showed her husband she did not ignore his

health problems. This is an example of Somsong's attempt to provide her husband with additional treatment. The involvement of receiving the information from the neighbours and care about her husbands' feelings governed her accounts of realising her responsibilities as a stroke carer.

Similarly, Somchat (pair 1) said that he had spent 400,000 baht on curing his wife from the stroke since the stroke onset, over more than nine years. Some neighbours talked about whether or not he was critical of the amount of money that he paid for extra medical treatment. He described his feeling when he heard the neighbours' words:

> I have never ever regretted paying for curing her (his wife) of the stroke. It is because we have made and saved money together. I have to look after her (line 92-93).

Somchat spent his savings on curing his wife of stroke, and their neighbours knew about this issue. From his excerpts, he did not state that the neighbours influenced his responsibility in taking on the caring role for his wife, but the neighbours' opinion contributed to his thoughts on the role.

The impact neighbours had on carers appears to be a dimension which influences the thoughts of carers and their awareness of commitment to the continuation of their caring role. The neighbours acted as a stimulant to the carers' encouragement and realisation of the caring for stroke survivors. Once the carers were influenced by the neighbours' opinion it was seen to contribute to the carers' expression of emotions and feelings towards daily living with stroke survivors. It demonstrates that the influence of neighbours could be identified as an impact of local social interactions.

7.5 Conclusion

In this chapter carers' accounting for their care of stroke survivors are identified as an overarching theme. The emergence of this theme is governed by the carers' core experience and feelings during daily living with stroke survivors. This theme

consisted of three subthemes which linked to each other and are able to explain the trajectory in carers' accounts of caring for stroke survivors. 'Becoming a main carer' subtheme referred to internal factors which persuaded carers to undertake the caring role for stroke survivors, whereas the 'influence of neighbours' subtheme was an external factor which enhanced carers' will to continue the carers' role. The 'carers' attitude towards stroke survivors' subtheme presented the evaluation of stroke survivors' physical ability to undertake activities themselves which was underlined by carers' thoughts.

The main findings illustrate the significant difference in providing care for stroke survivors between the early months post-discharge and the next stage of the stroke. In the early stage the focus for carers was on how to look after stroke survivors and how they sought the way to recover the survivors' abilities. Carers' highest expectation for stroke survivors was a return to prior abilities before the stroke. Carers seemed to concentrate on facing problems and tried to adapt themselves to fit given situations. This stage was a short-term period that ended when stroke survivors started to help themselves. The later stage referred to when carers reconsidered long-term priorities in their lives. Carers had experienced changes in life situations so far. In this stage they also needed to restore and to keep the balance between caring for stroke survivors and other aspects of their lives, e.g. family matters, working for a living and social participation.

According to the later stage, the focus for carers was now on the establishment of life priorities. However, stroke survivors were still positioned highly within the carers' considerations. The way carers paid attention to the survivors was different from the early stage of the stroke. Carers appeared to accept stroke survivors' residual abilities and to try to rearrange their existing lives. They learned to integrate caring for stroke survivors with their everyday activities. Successful integration involved care work being merged into carers' daily routine. It meant that the activities carers provided for stroke survivors were just additional work which was determined as a matter of their routine rather than doing care work. It implied that stroke survivors were a part

of carers' everyday lives, and the existence of stroke survivors also gave meaning to carers' lives.

Finally, it was apparent that stroke survivors received great support from carers and that the carers were identified as an important person in stroke survivors' lives. Carers understood their current life situation and the need to adapt it for living with stroke survivors in the family home. Carers tried to lead a normal life, despite their changing role.

In the next chapter the focus of analysis is stroke survivors' and their carers' experiences of managing their emotions in the context of daily living.

Chapter 8

Emotion Management:
Developing Accounts of Caring Interactions

8.1 Introduction

Emotion management emerges as a major theme from the data gathered from all methods, i.e. interviews, observations, and field notes. In this chapter, the main body of data comprises detailed observations of specific incidents in the practices of each stroke survivor-carer pair. The data from interviews are used for confirmation of understanding. Therefore, the presentation of this overarching core theme is mainly associated with data from interaction and communication between stroke survivors and carers and from the way they reacted to each other in given situations.

The concept of emotion work is connected to unpaid work and exists in the private realm. It refers to the consideration of how people manage their own emotions and feelings for sustaining a display of their outside manner (Hochschild 1983). This involves how individuals make sense of what emotions and feelings are appropriate and inappropriate in a given situation. Emotion work is divided into two kinds, surface and deep acting. It takes place when individuals have an emotional misfit in a specific situation and make an effort to achieve an emotional reaction accepted by social norms. The emotion work process includes not only the personal ways in which individuals experience emotion management, but is also determined by feeling rules which link to the influence of social regulation. Feeling rules (see section 8.4.2) arise out of external factors, i.e. social guidelines, culture and subculture, and the rules from different societies are able to influence each other over time (Albas and Albas 1988; Garey and Hanson 2011; Hochschild 1979; Smith 2012).

This chapter explores the conscious process of emotion work taking place during the stroke survivor-carer interaction through an ethnomethodological perspective. Ethnomethodologists seek to explain the methods and accounting processes that

people use for constructing their social world in relation to the environmental circumstances in which they occur (Denzin 1969; Garfinkel 1967; Maynard and Clayman 1991; Zimmerman 1978). The aim of an ethnomethodological approach within this study is to understand what practical actions and methods stroke survivors and carers use to give an account of caring interactions especially emotional issues in their daily living; how they made those practical actions and methods intelligible to each other and produced orderliness; how stroke survivors' and carers' accounts influenced methods they used to manage their emotions and feelings; how particular feeling rules shaped their account of emotion work in any given situation.

The theme of 'Emotion management' consists of three subthemes, i.e. emotion work as part of daily life, emotion work as reflection, and gender differences (see also Figure 4.1, p. 89). This chapter is outlined in the following way. Firstly, the situation of emotion work occurring during caring interactions between stroke survivors and carers is discussed in each pair. Then, the discussion of three subthemes relating to the emotion work observed in specific situations and presented as vignettes is illustrated.

8.2 The vignettes of caring interactions

The following data analysis presents the accounts of stroke survivors and carers in actual situations. This emphasises the embodied nature of emotion work in caring interactions between stroke survivors and carers within the practical context of care tasks. The central concern during collecting observational data was the intention to reveal the significance of emotion work within interactional situations and to acknowledge its existence.

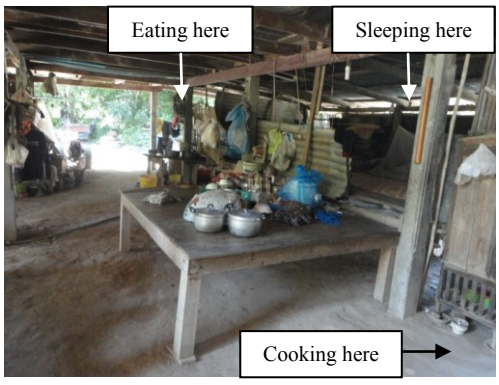
Twelve vignettes of caring interactions between stroke survivors and their carers are presented in order to afford insights into the interactions from each pair, drawing primarily on observational data. Furthermore, with participants' permission, I took photographs of their homes in order to illustrate the living situations of the participants. Each observation period was around one to two hours, depending on

how long participants permitted observations and/or the quality of observational data collected. The majority of observational activities were carried out after the interview session. All participants had also given permission for observation before becoming part of my study. I also asked participants' permission to carry out observation in their preferred location. This was to check they were still comfortable for the observation to take place. I encouraged participants to ignore my presence and carry on with their daily routine. In the early stages of observation, participants found this difficult; they always looked at me. After a time they began to ignore me when they realised that I did not bother them with matters concerning the observation.

Excerpts from observational data I have selected for stroke survivors and carers have the potential to reveal visibility of emotional expression during caring interactions. The data represented the surface expression of participants' emotions. I take these in conjunction with field notes and interview data relating to observational data to enhance understanding of stroke survivors' and carers' accounts of emotion work. This is done to discover any significant differences in the various forms of feeling rules and the nature of emotion work between stroke survivors and carers and/or the different methods used. The relevant details of participants' personal backgrounds were provided in Chapter 5).

Pair 1: Somsri (wife-stroke survivor) and Somchat (husband-carer)

The photographs below show Somsri's and Somchat's house where the ground floor was modified for living space. Somsri always stayed at home alone during the daytime, while Somchat worked outside. He went out around 7am and came back home around 5pm. Sunday was his day off.



The following scene is presented in order to display Somsri's and Somchat's emotions in caring interactions. The photographs above show their house and living space:

> Somsri was preparing food for dinner and showed me how to cook. She spoke proudly during making chicken curry. She used her left hand actively, and her right hand was used for providing a little help to complete each task. It appears that she is proficient in using only her left hand to accomplish tasks (She has mainly used one hand to do things for nine years). She stopped speaking when Somchat reached home. Somchat looked very tired. He said hello to me and asked, "Can you wait for me for half an hour?" I said, "Yes, take as much time as you want. Do you want me to come on another day? " I responded like that because of his appearance. He answered, "Today suits me." I then moved to a bench nearby and spoke to Somsri's older sister. He smiled to me and walked towards Somsri after putting his bag on the table next to me. He gave Somsri a small smile and said, "What are you cooking for tonight?" She answered without looking at him, "Chicken curry". She still concentrated on her cooking. Somchat still smiled and said: "Smells good". Somsri looked at him and smiled after hearing his words. Somsri asked Somchat to pick up from there with the cooking. Somchat obliged her and showed no expression on his face. They talked to each other sometimes. They finished cooking twenty-five minutes later. Then, she asked him to carry a gallon of water to her flower garden, "Can you carry it to the garden?" Somchat raised his voice, "Now! Do you want me to do it now?" Somsri looked at his face for a few seconds and said nothing. She started to walk to her garden. He shook his head slowly with a sigh before saying with a soft voice, "Sit here, please. I will do it for you after the interview. I need some rest. Are you OK?" Somsri said with a little smile, "OK". Somchat nodded to Somsri (Observation, 12/12/11).

The interpersonal context of this scene has shown different views of a care task. For Somchat, care tasks were to undertake household labour where the work used to belong to Somsri, as he said, "household chores are her duty" (line 143). It implies that he had never done housework before Somsri's stroke event. His caring activities were to assist Somsri with completing housework. He knew that she tried really hard to be able to do housework herself. Although Somsri seemed to be able to dominate Somchat to do many things for her, there were, however, instances when Somchat had authority over Somsri, this was evident in expressions such as raising his voice, shaking his head and sighing.

"What are you cooking for tonight?" was a way Somchat performed to enhance Somsri's confidence and make her feel good in a given situation. From the way he talked and smiled it appeared that Somchat tried to hold a friendly conversation with Somsri. Furthermore, his statement: "Sit here, please. I will do it for you after the interview. I need some rest. Are you OK?" may be an expression of sympathy. The following description of Somchat's feeling experiences towards his wife were related to sympathetic feelings:

> I know that I hurt her feelings through a loud voice sometimes. It is because I am tired from work. I cannot repress a sudden desire to shout when she orders me to do many things…but I then realise that I should not shout at her because she does not pretend to be like this (having physical limitation)…It seems like I allow a slip of the tongue. However, I stop the feeling of anger that I have because I understand her (line 36-38)…She has become touchy after having a stroke. I have come to terms with her condition. There is no point expressing strong emotions to her (line 160-161).

The earlier scene illustrates Somchat's emotion work. He expressed both surface and deep acting in this scene. The former was shown when he smiled to Somsri despite being exhausted. The latter was presented during taking deep breaths in order to become calm and escape from the feeling of anger. It also indicated that the reason for his emotion work may be because he was sympathetic about Somsri's condition and/or he wanted to maintain a good relationship between him and his wife.

The quotation above revealed Somchat's account of care for Somsri's feelings. He had sympathy for her because he understood her suffering. In this situation, his feeling rules may be framed by socially constructed norms for the roles of husband and carer. He knew that he was supposed to act in a friendly manner and help her as usual. It appears that he broke the rules when he became angry with her. At that time he realised that his underlying emotional state did not fit those feeling rules. He tried to reshape his emotional response and manage his emotions by taking deep breaths and then he could finally express appropriate behaviour.

Emotion work was also evident with Somsri. She was disappointed with Somchat that he refused to follow her request. She had strong feelings due to previous

experiences of Somchat's indulgence towards her. She responded by looking at his face and intending to go away from the specific situation. It seems that she tried to evaluate the degree of Somchat's emotions. She knew that she should not feel angry and be aggressive with him as part of her feeling rules. This feeling may be guided by the norms of behaviour in marital relationships and in gender roles.

Somsri decided to suppress her emotion in order to protect Somchat's feelings by saying "OK" with a little smile to him. The way she behaved looked like the expression of surface acting. It appears that she was unable to manage her emotion at that time. However, the procedure to establish deep acting can be located in Somsri's accounts. The following excerpt shows Somsri's account of feeling grateful to Somchat. The feeling of gratitude seems to influence her realisation of emotion management. The realisation took place inside Somsri's mind in the same way as deep acting which was grown from individual inner feelings. Somsri indicated:

> He (Somchat) looks after and supports me to continue to live every day (line 32)…I think that he is tired from his work as well as from me…I try to help him as much as I can. This is to help reduce his tiredness and to make him feel happy as much as possible (line 48-49).

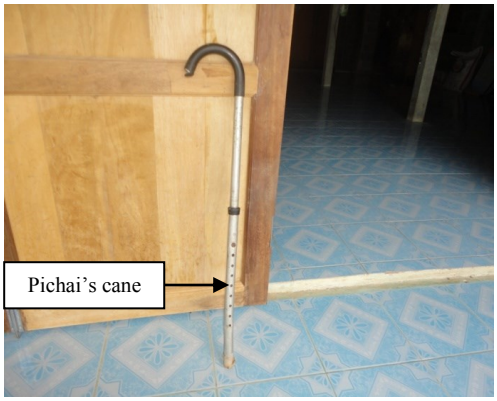
The relevant data give a summary of Somsri's and Somchat's emotion work in relation to deep acting. The significant influence on Somsri's accounts for managing her emotions was the feeling of gratitude to Somchat, while Somchat feels sympathy for Somsri because of her stroke. Furthermore, it became apparent that Somsri's and Somchat's beliefs about karma doctrines may be a contributing factor to guide their deep acting in the decision-making process of emotional response. Buddhist beliefs about karma helped them to accept and to realise their life situations, as they said:

> A full recovery from stroke has never happened. I have to be like this…It (stroke) has already happened. I must accept my fate (line 134-135)…They (older people and folk doctors) told me that it is because of bad karma from my past deeds. It (stroke) cannot be cured. It is a karma illness (Somsri, line 163-164).

> It (stroke) comes from her bad karma. It is also mine (line 11)…When I think like this, it helps me to reduce my stresses (Somchat, line 14).

Pair 2: Pichai (husband-stroke survivor) and Supa (wife-carer)

Photographs below indicate a scene of caring interactions between Pichai and Supa. The photograph on the left shows a tree stub located beside their house which Pichai chopped and burned himself.



Pichai was lying on the sofa and seemed to be thinking about something because he appeared distracted from his television which today did not have his favourite programme, boxing. He looked bored. Sometimes, he frowned...Supa went out from the toilet and walked straight towards him. She sat next to him and said funny things. Pichai still kept watching television without speaking. Supa went to me and said with a little smile: "He always acts like this when he is dissatisfied with something. Let him be and take a rest. He will forget when he wakes up."...Pichai stood up a few minutes later and turned his head to Supa.

Pichai Shall we go to do it?
Supa Not now
Pichai If you do not help me, I can finish it myself. (He scowled at her and walked to the back of the house.)
Supa Where are you going?

Pichai came back with an axe in his right hand and held a cane in his left hand. He walked straight at a dead tree beside the house. I later understood this reaction after talking with his daughter who informed me that Pichai had asked Supa to cut this tree for a week, but she ignored his request. He therefore decided to do it himself...Pichai sat next to the dead tree. He held an axe with his left hand and chopped down the tree continuously. His action made Supa laugh. She raised her voice and still laughed: "Stop doing that. I will cut the tree for you this weekend. Are you OK?" There was no answer from Pichai, and he continued to chop the tree. Supa reached him and said, "I will help you." She stopped laughing in front of him. Pichai only looked at Supa and kept doing it. Supa said and smiled at him: "Please let me do it for you. I am sorry." Pichai chopped the tree a few times and spoke in a monotone: "You grip the top of the tree for me. I will chop it strongly. It is easier." (Observation, 24/12/11)

This represents another care task. Supa helped Pichai to achieve his task in daily living. Pichai had intended to cut down the dead tree for a week. This issue seems to be a little thing for Supa but it was big for Pichai. The scene illustrates that Pichai felt disappointed because Supa did not do a job as he requested. He tried to show what he felt, but Supa did not get it. It is clear that Pichai failed to suppress his emotion at this time. Pichai kept the feeling of anger with Supa, whereas Supa ignored Pichai's action. In this scene, Supa claimed that she experienced similar situations many times: "He always acts like this when he is dissatisfied with something. Let him be and take a rest. He will forget when he wakes up." Unfortunately, her thoughts were not correct in this case. Pichai said, "If you do not help me, I can finish it myself." This statement confirmed that he was very temperamental as Supa described: "He is easily upset. He is also a bit offended when I do not pamper him" (line 123). However, the way Pichai scowled at her, walked into the storage room and came back with an axe concerned Supa. She realised that Pichai was quite moody, but she left him alone and still laughed at him. It appears that Pichai became angrier at Supa's action. While Pichai was chopping the tree with one hand, Supa reached out to him and said, "I will help you." This fragment shows Supa's emotion work and her feeling rules. She knew that she should not laugh at him because it was not a laughing matter. She stopped laughing in front of him because she realised that she should feel sympathetic about his fate (having a stroke and physical limitation) rather than laughing at his misfortune. She kept calm by stopping herself from laughing in order to calm Pichai. She let him know that she apologised for what she had done. The reason why she could easily manage her own emotion may come from the inside of her feeling towards Pichai as Supa claimed:

> I worry about him because I love him so much. I cannot break off our relationship. I pity him…I am unable to leave him although he used to hurt me many times…He always physically abused me, especially when he drank…I have felt more safe since he had a stroke…He cannot hurt me, (laughing) and I do not worry about this issue anymore (line111-113)…He is a part of my life. He did a lot of good things for me more than doing bad things…I cannot leave him because of love and pity. We also have children (line 156-157).

Excerpts above illustrate that Supa was satisfied with her recent life situation. The stroke contributed to a better life and enhanced a good relationship between her and

Pichai. The power of love and the feeling of sympathy drove Supa to overlook how Pichai used to abuse her. All factors here may regulate her accounts to adjust her inward emotions and feelings. It appears that she could suppress unsuitable feelings and express managed feelings easily as she said and smiled at Pichai in the fragment: "Please let me do it for you. I am sorry."

Pichai's emotion work can be seen from the scene. The way he looked at Supa and kept chopping the tree showed the process of managing his emotions. He took some time to overcome his feeling of dissatisfaction. He knew that he should not feel dissatisfied with Supa because he felt indebted to her for all help as he stated: "I feel pity for her (line 37)…She is very important for me because I know that I have no chance to make a full recovery" (line 81). The feeling of gratitude for his wife may spring from Pichai's feeling rules which guided him to think in that way. The scene also presents how he used surface acting to suppress and express his emotions and feeling as he spoke in a monotone and said: "You grip the top of the tree for me. I will chop it strongly. It is easier." It appears that he still felt moody, but he could suppress this feeling and expressed peaceful mannerisms in this given situation.

Pair 3: Prasit (husband-stroke survivor) and Somsong (wife-carer)

After the interview session, Prasit walked to a small tractor and looked it over, whereas Somsong went into the kitchen to prepare dinner. Their son sat in an armchair nearby Prasit and played with a toy soldier. When checking the tractor, Prasit often glanced at his son.

> Prasit had tried to open the tractor's engine for around ten minutes. He looked around when he seemed to need some help. He decided to ask his son to call Somsong for him. His son went to the kitchen. Somsong shouted from inside: "I am cooking. What would you want?" Prasit showed no response to Somsong's question. He kept trying to open the cover. His son went back to the toy. A few minutes later, Somsong went out of the kitchen and said to her son: "Play carefully." She frowned and walked straight at Prasit. She raised her voice and asked him: "Didn't you hear me? What do you want? I am cooking. Hurry up." Prasit looked at Somsong's face: "Are you angry at me?" He gave her a big smile: "Sorry, I didn't hear what you said. I just needed your help. There is something wrong in the engine. I want to open the cover to check it carefully. You already knew that I will use the tractor tomorrow for work."

> Somsong smiled at him and said softly: "Could you wait for five to ten minutes? I am almost finished cooking." Prasit smiled and said: "Sure." Somsong went back to the kitchen. Prasit looked at her, smiled and shook his head. He turned back to his work. Around ten minutes passed, Somsong came back to Prasit. "How would I help you?" Prasit smiled at her and explained how Somsong can help him. They help each other to open the cover and do something with the engine (Observation, 7/11/11).

The scene above indicates a care task that Prasit received from Somsong in order to succeed in a piece of work. This care task may be taken for granted as a care activity by Somsong for two reasons. Firstly, she described what care she provided for Prasit after he could walk himself: "I just prepare food and medicine for him every day" (line 194). Secondly, she was highly satisfied with Prasit's physical ability because he was able to work almost equal to the majority of people. Somsong stated:

> I would not be able to do the rice farming if I did not have him. I cannot drive the tractor, but he can. He also can irrigate fields, and I just give him a little bit help for that (line 38-39)…He is very hard-working (line 163).

The way Prasit gave a big smile to Somsong and asked her: "Are you angry at me?" and that he shook his head and smiled after Somsong went back to the kitchen confirmed the realisation of Somsong's emotions. He should have felt anger towards Somsong for the way she behaved, but he induced a good response in her. It is clear that Prasit's emotion work is illustrated by this fragment. His emotions and feelings seem to be adjusted from inside, hence engaged in deep acting. He appeared to regulate deep feeling without potential tension between what he actually felt and his expression. His emotion work may be as a result of his knowledge of his feeling of gratitude for all Somsong's help.

Somsong frowned and walked straight at Prasit. She raised her voice and asked him: "Didn't you hear me? What do you want? I am cooking. Hurry up." This fragment shows Somsong's emotion at that time. She felt angry about being interrupted. She went out to meet him because she knew that Prasit needed her help, but she could not stop this feeling. She faced him with the feeling of anger. When she reached him, she realised that she should not feel angry at him. Prasit has weakness on the left-side of his body, and he really needed her help to finish the important job for their rice farm.

The sense of the caring role and the quality of a good relationship between them may frame Somsong's feeling as to her feeling rules for this situation.

Somsong smiled at him and said softly: "Could you wait for five to ten minutes? I am almost finished cooking." This fragment shows Somsong's emotion work. She could adjust her emotions and feelings to match the given situation. From the way she changed her body language it appears that her emotions could be controlled easily and naturally from deep feeling. This may be influenced by her feeling rule regarding the feeling of gratitude to Prasit for what he had done for her.

Pair 4: Samart (husband-stroke survivor) and Mesa (wife-carer)

After the first interview, Samart and Mesa invited me for a little refreshment. They said that they would be disappointed if I refused to join them. I really appreciated their kindness. During the refreshment period, I raised general topics in talk. It appeared that they were interested in buying a chicken farm. Samart said that his aunt would give him a loan to set up a small chicken farm after he recovered from the stroke, while Mesa was looking at him with hope in her eyes. The observational data below were obtained after the refreshment time.

> Samart lay on the big table modified as a bed, while Mesa was carrying glasses and plates into the kitchen. She went out from the kitchen ten minutes later. She sat in a hammock nearby. Mesa gave a big smile to Samart and said: "It is time to exercise. Today, I have not seen you walk so far. Are you ready?" Samart turned his face and looked at her: "I need more rest. I don't want to walk now." Mesa shook her head: "Don't be lazy. I think you have rested enough. Aren't you feeling well? If you are not like that, you have to move." Samart sighed and moved his body slowly. He held the bamboo handrail fixed to the table on his right hand side in order to raise himself up (see the photograph below). Mesa stood next to him and let him stand up himself. Samart frowned and cried: "I feel pain here." He pointed at his left calf. Mesa reached to support him and looked at his calf: "It is OK. You have pain because you don't use it that much. Please relax. You will feel a lot better. I will support you. Don't be afraid of falling." Samart appeared to be calm after taking a few deep breaths. He seemed to be already tired when he stood up. He took deep breaths and tried to stand straight. Mesa smiled at him: "Very good. When you are ready, go slowly and carefully." She then assisted him to reach the exercise rails. Samart did walking exercise for around forty-five minutes. Mesa walked along with him and cheered him up (Observation, 11/11/11).

Samart demonstrated emotion work when he was feeling bored and tried to suppress the feeling as he stated: “I need more rest. I don’t want to walk now.” His body language, the way he sighed and moved his body expressed his feeling of reluctance to do his walking exercises. This statement accords with an excerpt from his interview: “I feel like a lazy person. My wife always encourages me in taking exercise, but I do not want to walk or to do anything” (line 11). Samart finally decided to follow Mesa’s suggestion. He knew that he should not feel bored and reluctant in this situation. He realised that walking exercises were good for recovery and that Mesa’s intentions were for his benefit. The act of obeying Mesa’s advice may be guided by the regulation of his feeling rules.

Being afraid of pain was another reason why Samart seemed to be unwilling to do any exercise as he stated, “I feel pain here (his left calf).” His surface acting was illustrated through body language. He suppressed the feeling of fear by taking a few deep breaths. Furthermore, the way Mesa gave him encouragement made Samart have confidence to walk when she stated: “It is OK. You have pain because you don’t use it that much. Please relax. You will feel a lot better. I will support you. Don’t be afraid of falling.” This fragment also illustrates Mesa’s effective way of encouragement for taking more exercise. As described in Chapter 5, pair 4, Mesa knew that Samart was not keen to do exercise. She tried many ways to persuade him to exercise.

Mesa shook her head: “Don’t be lazy. I think you have rested enough. Aren’t you feeling well? If you are not like that, you have to move.” This fragment shows that

Mesa felt dissatisfied when Samart tried to refuse to take exercise. She really wanted him to achieve full recovery and knew that exercising would be the best way to regain physical function from the stroke, as she stated: “I always say to him that you have to do more exercise and help himself…If you can help yourself properly, I will work to make money for living. I cannot stop working because our savings ran out” (line 21-23). Mesa realised that Samart was a good family leader, and he provided her with money. This made her grateful to him. Furthermore, Mesa spoke of love that she felt positive towards him and about their marital relationship. These factors would influence Mesa’s deep acting as illustrated by the way she spoke and smiled as illustrated in this fragment: “Very good. When you are ready, go slowly and carefully.”

Pair 5: Karun (husband-stroke survivor) and Pranee (wife-carer)

This was the third time that I visited this couple. The first two occasions for observations involved scenes of conversation between them and of Pranee preparing pills for Karun. For this time, I made an appointment with them in the early morning because I remembered that Pranee would go to the rice field in the late morning, and I wanted to observe other caring interactions between Karun and Pranee. For preventing ethical issues raised, I got their permission for using the following scene.

> When I arrived at the house, the front door opened, but nobody was there. I was surprised because Karun normally sat at a big table located in the front of the house. I heard a noise inside. I then walked to the front door. Karun stood with the walking cane in front of the toilet, while Pranee was cleaning the floor. Pranee said with a loud voice: “Why don’t you tell me earlier if you need the toilet?” Karun raised his voice: “I don’t want to be like this. I don’t want your help. I can clean myself if you are unwilling to do it.” She sighed and said: “I have to clean your faeces both on your trousers and on the floor. I don’t know why you don’t help me to reduce my work. I am very tired. I have to go to the rice field today. I am late now.” Karun responded by standing in silence. In this scene, I was unable to see Karun’s face because of standing with his back to the front door. Pranee finished cleaning and dressing Karun fifteen minutes later. She looked up to Karun’s face and lowered her voice: “I am sorry for what I said. I did not mean to complain to you about this, but I just want you to tell me earlier when you need the toilet. You already knew that I have to go to the field today for irrigating land. The rice field might be damaged if I am late.” Karun kept silent. Pranee helped Karun to walk straight to the front door. She smiled at me when she saw that I stood at the front door:

"I am sorry to keep you waiting. I have to go to the field now. Can you come to interview me at the field?" I smiled back and answered: "No worries" I looked at Karun's eyes and found that he appeared sad. Pranee then took Karun to sit at the table.

Pranee Are you OK?
Karun I am fine.
Pranee Good. I will come to take you to the field after finishing the interview. Are you OK for that?
Karun Yes, I am waiting for you (Observation, 3/12/11).

The scene above illustrates Karun's and Pranee's emotion work. In the early stage of the scene, Karun showed the feeling of anger as he started with a raised voice: "I don't want to be like this. I don't want your help. I can clean myself if you are unwilling to do it." This feeling may come from how Pranee behaved and presented her feeling of dissatisfaction through speaking with a loud voice in this fragment: "Why don't you tell me earlier if you need the toilet?" It appeared that Pranee's dissatisfaction with Karun was the origin of Karun's anger. The expression of Karun's and Pranee's emotions subsequent to this early interchange presents a trajectory of how they adjusted their emotions to become calm.

Following on from this it appears that Karun's anger turned to sadness. However, he could suppress his emotion by standing in silence, while Pranee continued complaining about this issue. Pranee was able to manage her emotion when she looked up to Karun's face. It appears that she felt guilty at that time. She apologised to him and tried to explain her manner as she claimed: "I am sorry for what I said. I did not mean to complain to you about this, but I just want you to tell me earlier when you need the toilet. You already knew that I have to go to the field today for irrigating land. The rice field might be damaged if I am late." It appears that they presented the surface expression of their emotions as surface acting in order to calm each other. Karun's silence tried to reduce Pranee's guilt, whereas Pranee tried to reduce Karun's anger and sadness by giving him an explanation and an apology for what she said. Furthermore, the conversation between Karun and Pranee at the end of the scene illustrates the confirmation of each other's calmer feelings.

The interview data sheds light on their feeling rules. For Karun, he realised that he should not feel angry at Pranee because she was the most important person for him, as he stated: "She is both my wife and my best friend" (line 43). Karun knew himself that he was rather temperamental so he was easily offended or upset by comments and/or behaviour in relation to his limitations: "I always think over and consider seriously for every story. Sometimes, I feel upset myself by thinking about nonsense (line 40)…I think that I became a touchy person because I was unable to do things as I used to" (line 52). It appears that Karun's feeling rules stem from the realisation of his life situation and the feeling of gratitude to Pranee.

For Pranee, she knew that she should not feel dissatisfied with this situation. She realised that she should understand Karun's physical limitations. Furthermore, Karun was a significant person for her as Pranee stated:

> He is important for me. He seems like my encouragement, although he is unable to work the same as before. He is also my consultant when I need some suggestion (line 151-152)...I do my best with my responsibility. I cannot leave him because we live together for many years (line 201).

However, Pranee indicated that she was satisfied with her recent life situation when she stated: "I had not been stressed since he had a stroke because he stayed at home and he did not go out to drink with his friends anymore. I was unhappy at that time. It is true that taking care of someone who had a stroke makes me tired, but I am happier than ever" (line 238-240). It appears that the sense of responsibility, the duty of wife and the quality of love may frame Pranee's feeling rules for this situation.

Pair 6: Umpa (daughter-stroke survivor) and Naree (mother-carer)

After Umpa was discharged from hospital with a weakened right side of her body following a stroke, her daily routine comprised physical exercises and looking after her little daughter. Umpa used to work as a nursing assistant in a community hospital that she drew on this experience to help her help herself as much as she could. Naree had become Umpa's carer since Umpa separated from her husband six months after the stroke event. The following scene from my observation indicates that there was a lot of conflict between her and her younger sister as she stated in interview: "My

adolescent younger sister always makes me get into a mess (line 91)…She behaves as a good girl in front of our mother, but she always goes out with her friends and does not help me to look after my daughter when mother goes to work" (line 135-136).

> Naree sat on a chair nearby the front door and kept her eyes on Umpa when she was walking without a cane from the front door to inside the house. Naree was in an alert manner to reach Umpa when she saw Umpa stumbled on the doorstep. Naree changed her mind about helping Umpa's walk when she knew that Umpa was still poised to stand. After Umpa was able to stand properly, Umpa and Naree looked at each other's face and laughed together.
>
> Naree You always do this many times (smiling and shaking her head). Be careful when you walk. What would you do if you hurt your head?
>
> Umpa No worries. I can stand myself. (looking at me and said that) Please don't say that. I am shy. It was because of my right leg (laughing).
>
> Naree (smiling back to Umpa)
>
> Umpa By the way, where does Umporn (her younger sister) take my daughter? (She raised her voice to call Umporn with an impolite word.)
>
> Naree Why do you say that word for Umporn? You should speak to her in polite way. She is your younger sister, and she helps you to take care of your daughter.
>
> Umpa I just call her because I want to know where my daughter is. I remember that I cannot touch your favourite daughter (I noticed the tears in her eyes).
>
> Naree looked at Umpa's face, sighed and shook her head a few times. She left Umpa alone and went back to talk with me, while Umpa was walking to her bedroom...Naree talked to Umporn when she got back home with Sunee (Umpa's daughter) around thirty minutes later...While Naree and Umporn were playing with Sunee on the big table in front of the house, Umpa walked out from her room and came to Sunee. Umpa gently fondled Sunee's head and scowled at Umporn. There were no more tears in Umpa's eyes, but the eyes showed sadness. Umpa spoke to Naree: "I am sorry for what I said to you." Naree nodded in agreement and gave her a smile (Observation, 11/11/11).

Although the scene above did not present Naree's care activities for Umpa, it showed the quality of love and care which Naree gave to Umpa throughout the scene. Naree worried about Umpa's safety. She had kept her eyes on Umpa since that time Umpa started walking until she was able to stand after stumbling on the doorstep. They laughed together after that event because they might have wanted to make one another feel less worried about the past event. The following excerpts from the scene

confirmed that Naree was worried for Umpa: “Be careful when you walk. What would you do if you hurt your head?” The quality of love and care could be demonstrated by the way Naree behaved, talked and smiled to Umpa during the interaction between them.

“No worries. I can stand myself.” This excerpt indicates that Umpa was satisfied with her ability. Umpa’s satisfaction turned to sadness when Naree confronted her on her unfriendly behaviour towards her younger sister. Umpa seemed to be very upset to hear what her mother said to her. She believed that her mother loved her less than her sister because she had a bad husband. In the interview data, Umpa claimed:

> My younger sister always caused me to quarrel with mother…Sometimes mother listened to my younger sister. Sometime she believed in what I explained. I knew that mother did not believe in me because of my husband (line 137-139)…At that time I married my husband. My mother said that I had to accept the following results because I chose him myself (line 142-143)…I think that my mother loves my younger sister more than me…I want her to understand me (sighing) I want her to encourage me. I feel neglected (line 173-174).

In the observation, Umpa could not hold back her tears because of her sadness. The expression of Umpa’s feeling was compatible with how she felt, and she could not suppress the feeling of sadness at that time.

However, Umpa’s guilt is shown at the end of the scene. The feeling of sadness was presented through her eyes, and the way she spoke to Naree: “I am sorry for what I said to you.” It appears that consideration of how Umpa should behave to Naree underlay Umpa’s decision to apologise to Naree for her mistake. She felt guilty and chose to say sorry because of her feeling rules which may be framed by the feeling of gratitude to Naree and also because of cultural rules about mother-daughter relations. As Umpa stated: “My mother did me favours (line 93)…She always does good things for me” (line 139).

Naree’s emotion work is also illustrated through this scene. The way she looked at Umpa’s face, sighed and shook her head a few times presented her dissatisfaction

with how Umpa behaved towards her. She decided to leave Umpa because she knew the way to calm Umpa's emotions and feelings. As she said in interview: "I know Umpa very well. She is very touchy...I always ignore her and leave her alone when she is upset, angry or unhappy...She will come to talk normally to me after being able to calm herself down" (line 53-55). However, it appears that Naree could adjust her deep feelings from inside. She expressed deep acting when she gave Umpa a smile at the end of the scene. Naree knew that she should not feel angry, upset or dissatisfied with what Umpa said to her because she understood Umpa's feelings. The quality of love and care may guide Naree's feeling rules.

Pair 7: Nisa (wife-stroke survivor) and Prakit (husband-carer)

This is one of two pairs in which stroke survivors and carers had an unpleasant relationship. From the interview data, Prakit had taken care of Nisa since she was discharged from hospital although they were in conflict with each other. He had provided total care for her until she was initially able to help herself. Since then Prakit let Nisa take care of herself, and he only provided food and gave her money for living. In each visit, I found that Nisa and Prakit only stayed a short period in the same place as each other. They hardly spoke or interacted with each other during the observation periods. It seemed that they intended to ignore and tried to avoid one another. However, there were a few short scenes in relation to caring interactions between them. The following scene happened in the second visit. Although I witnessed this before they were aware I was present, they allowed me to use this scene after I showed them what I observed.

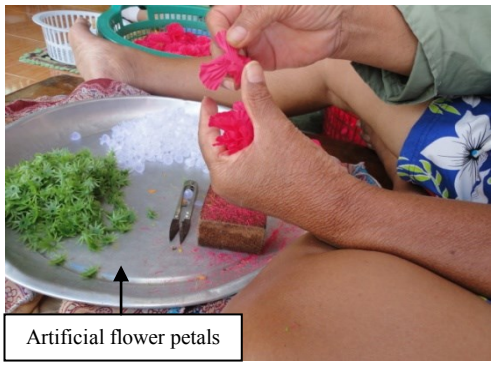
> I reached their house in the morning. I intended to be outside awhile in order to observe their activities without my involvement in the situation. I could see inside from that place, but I was unable to hear what they said. Nisa sat at a big table modified as her bed, while Prakit was washing dishes in the kitchen. He then brought clothes to her five minutes later. Nisa received the clothes back from Prakit and kept them in place. They did not speak to each other and remained expressionless. They also barely looked at one another's face. I entered by the front door. Nisa gave me a friendly smile. Prakit greeted me with "Hello" and went back to do housework. He let me talk to Nisa first. I interviewed him later…After the interview period, Prakit was preparing himself to go for work, while Nisa still sat at the same table. She told me that she was going to her sister's house. I then said thank you for their time and

> good bye for now to them. Before I left their house, I found that Nisa stood up and started to walk without a walking stick. While she was lurching forward and almost falling, Prakit reached her and helped her stand properly. Nisa said with a small smile: "Thank you" Prakit looked at her face and nodded. He still kept silent and expressed expressionless face. Nisa sat at the table again and took deep breaths. She took a walking stick in her right hand and started walking (Observation, 18/11/11).

There was a lot of conflict between Nisa and Prakit as discussed in Chapter 5 (pair 7). In a tense atmosphere, the scene shows some care tasks that Prakit undertakes for Nisa, i.e. preparing food, doing housework and washing her clothes. It appears that he fulfilled her basic needs for daily living. This scene also confirms that they still had conflict. Prakit kept taking care of Nisa, and they still lived together. However, it was observed that it might be difficult for them to live in conflict. During the interview session, they stated that they had their own emotion management when they faced difficulty in their lives. As the following extracts illustrate:

> I pray to Buddha at bedtime. I concentrate my mind before falling asleep…I believe in Buddhist doctrine. I try not to be distracted by what other people say about me. I also try not to listen to them. Let it be (line 78-79)…I am happy when I am here (her sister's house where she works combining three parts of artificial flower petals as the photographs below demonstrate; she appears relaxed doing this job) I have laughs. I feel good when I leave my house (Nisa, line 286).

> I always find a silent place. I sit under the tree and cry as much as I want for releasing my distress. I am relaxed after doing that. I have no one to share distress so I have to help myself (Prakit, line 158-160).



The words 'Thank you' Nisa said to Prakit when he helped her from falling illustrate Nisa's emotion work which was surface acting. In this situation, she knew that she

should forget feelings of conflict towards him. She should demonstrate being grateful to him, and her feeling may be guided by the feeling rule of gratitude. For Prakit, he also expressed surface acting when he looked at Nisa's face and nodded after hearing her words "Thank you." It meant that he accepted Nisa's gratitude for the recent situation, but he still had a feeling of conflict with Nisa. However, this scene demonstrates at least that Prakit worried about Nisa's safety. His feeling rules may be framed by the quality of his responsibility and the husband's role.

Pair 8: Duangjai (mother-stroke survivor) and Pracha (son-carer)

Pracha always stayed with Duangjai almost all the time. He left her for short periods to go to the toilet and/or to do his personal things. He also prepared food for her and they had lunch together.

> In the living room in which there were a lot of images of Buddha and two photographs of Duangjai's parents (data from the first interview) hung on the wall, Duangjai sat on the bed located in front of a new twenty-nine inch television. This is a place in which she always stayed during the daytime. There were a water jug, a glass, a small mirror, a pair of glasses and a few books on a small table next to her bed. Pracha, her son and her main carer, sat in front of a desktop computer oblique to Duangjai's bed. He often glanced at his mother throughout using his computer to read news and play games sometimes, while Duangjai was watching a comedy show on the television. She seemed not to pay attention to this programme because I had never heard a laugh from her despite watching a comedy. They had not talked to each other for twelve minutes after the observation began…until Pracha asked, "Do you need to go to the toilet?" when he noticed that his mother looked at him a second time. Duangjai did not say a word. She just gave him a thin smile and nodded her head. Pracha hurried to reach her and left his game without finishing it. Duangjai was moving to the edge of the bed whereas Pracha was in front of her and raised her up. He stood on the right side of his mother. His left arm held her waist, and his right arm grasped her right arm. They were walking carefully to the toilet next to the living room. He said without any expression on his face "Go slowly" and looked at Duangjai's face gently. Duangjai stopped rushing. He asked "Can you hold it?" She said smiling "Yes". They took around three minutes to reach the toilet and spent a few minutes in the toilet. Pracha left the toilet door ajar and sat in a chair nearby after he prepared Duangjai for toileting. Around ten minutes later, I heard a word "finish" from the toilet. Pracha went into the toilet and took Duangjai back to the bed. He then sat at the computer desk. They did not exchange any words after the toilet (Observation, 20/11/11).

The above scene illustrates that emotion work merged with Pracha's routine care task. The emotion work activities concerned behaviour immediately during the care task, and the aim of these activities appeared to be to avoid hurt to one another's feelings. The way they behaved towards each other suggested that they knew what one another wanted although they did not speak. Duangjai was feeling nervous because she was afraid that she might not reach the toilet in time and make a mess. She tried to suppress the feeling of anxiety by stopping herself panicking and saying "Yes" because she did not want to pressure her son. Pracha felt worried by his mother. He always remained alert to his mother's needs. However, the way he acted and his statement "Go slowly" when he provided care for his mother seemed like he was trying to reassure himself and his mother. This reassured her that he could manage this task effectively in order to prevent her from stress.

The way Duangjai and Pracha managed their own emotions could be explained through understanding the power affecting their personal accounts. Duangjai's accounts were influenced by her strong beliefs in Buddhism. Duangjai accepted her life situation as she indicated: "My bad karma makes me be like this" (line 114). She took the Buddhist teaching to control her mind and manage her emotions and feelings in everyday life:

> All are very good ways to lead my life (pointing to the images of Buddha on the wall) (line 90)…It (stroke) used to be torment for me. I gradually controlled my feelings. I am better now (line 96)…I make Bun (good behaviours and donations) as many times as I can (line 168).

Pracha's accounts were influenced by the sense of gratitude. His sense of gratitude is evident in his behaviour in front of his mother as he mentioned: "I try to be in a good mood for her as she is very sensitive. I do not want her to see my bad moods" (line 26). The intention to return good things to his mother was Pracha's aim: "We (he and his mother) are very close. She has done many good things for me, and I recognise them. So I have to look after her back" (line 157). He realised that he was under stress. The stresses contributed to his illness, hypertension. He was taking medicine for hypertension every day for two years. However, he employed strategies to reduce his stress: "Watching television, going on the internet and reading books are the

ways I release my tension. Although the stresses do not totally disappear, these strategies help me to stop them for awhile. Stresses are recurrent sometimes" (line 34).

From their accounts above, the activities of Duangjai's and Pracha's emotion work appear to show that they are doing a kind of deep acting in order to control the expression of their emotions and feelings. From interviews, their inner feelings were developed by using their own accounts and personal beliefs including the relationship between them. The following excerpts described what Duangjai and Pracha recognised in each other in order to understand the quality of their relationship:

> He (Pracha) has never given any offence to me…He always speaks politely to me. He thinks I may be sad if he offends me. He is a silent person. I think he may be stressed. Sometimes I am stressed because I feel pity for him (line 41-42)…He graduated with a bachelor's degree from the university at the same time that I had a stroke. He then did not work…I wanted him to work outside like his sister…He refused to go to work and stays at home to take care of me instead (line 160-161)…Sometimes I feel stressed. I smile and hide my feelings because there is no point in letting someone know what I feel (Duangjai, line 163).

> I planned to work in Bangkok. I already received an offer of a job at that time, but I have to refuse (laughing despite expressing sadness through his eyes)…It was because my mother felt terribly sad about it. She cried and did not let me go. She was afraid of being abandoned (line 8-9)…We could not hire someone to take care of her because her moods swung easily. She is a stressed person. If there is something bad affecting her mind, she will lose her control…She has extreme emotions. When she loves or hates someone and/or feels sad, these emotions are expressed extremely. But she looks like a woman who is peaceful. She always smiles and keeps quiet (line 58-60)…I take care of her as a matter of routine. I know that it may not be perfect. Perhaps she may not be satisfied, but she does not tell me. She is afraid that I will feel uneasy or angry about that (Pracha, line 251-252).

It is visible from Duangjai's and Pracha's accounts that they were considerate of one another's feeling. The quality of love between mother and child and having a firm family relationship seemed to drive Duangjai's and Pracha's accounts of commitment to maintain a friendly manner to one another. This information also leads to the understanding of their feeling rules which guided them to suppress and

express their feeling in a specific way. Duangjai's feeling rules may be related to motherhood and the norms of behaviour in family relationships. Pracha's feeling rules may be related to the norms of respect and gratitude to parents.

Pair 9: Sumet (husband-stroke survivor) and Wipa (wife-carer)

This is an example of an unpleasant relationship in a couple who had personal experiences with stroke. It was difficult to see both of them together because Wipa had to go out for work in the early morning and returned in the late afternoon. Sometimes, she came back home for lunch. The following scene happened when they had lunch together. However, they hardly spoke to each other and rarely stayed in the same area with each other.

> I sat on a bench in front of Sumet's home after finishing an interview with him. At the same time Wipa was coming. Her ten-year-old granddaughter ran to her and they embraced. She saw me and said: "Do we have an appointment the day after tomorrow?" I said: "Yes. Could I sit here for work?" She gave me permission and smiled: "Yes, you can." I smiled back and said: "Thank you." She walked along with her granddaughter and gave Sumet a sidelong glance. She sighed and asked him: "Have you had lunch yet?" He looked at her face and answered with no facial expression: "Not yet." Wipa entered the kitchen, while Sumet was watching television. Sumet then walked to the dining table. Around ten minutes passed, Wipa carried a tray of food and put it in front of Sumet. She said: "We should eat together." She put some rice in his bowl and never said any words to him since then. She talked about general topics with her granddaughter and smiled at her often. It appears that Sumet had lunch alone. He tried to make eye contact with her, but she had never looked at him during the lunch period. He looked sad and disappointed which were presented through his eyes. They finished lunch twenty minutes later. Sumet gave a little smile for Wipa when she served him a glass of water, while she showed no facial expression and said nothing. Wipa carried food containers back to the kitchen and cleaned the dining table, while Sumet did nothing. She looked at him and sighed again, whereas he walked to the sofa and watched a television programme. Around five minutes later, Wipa came out from the kitchen and spoke a few words to her granddaughter. She went past without looking at him and rode off on a bicycle to work. He just glanced at her as well (Observation, 20/11/11).

This scene illustrates an embarrassing situation taking place when Wipa prepares a meal for Sumet. As indicated in Chapter 5, they had an unpleasant marital relationship. The interaction between them appears as a struggle to communicate

with one another. It is clear that Wipa behaves differently with Sumet and with her granddaughter. She displays overt happiness in her granddaughter. On the other hand, she avoids expressing any emotions to Sumet. For Sumet, he tried to suppress his emotions in front of Wipa as well. Caring interaction was a trigger for revisiting personal experiences of the unpleasant relationship between them.

Emotion work was shown by Sumet and Wipa throughout the above scene. Sumet suppressed his feeling of being neglected and kept silent through the presentation of surface acting. He knew he should not feel hurt because she worked hard both for living and in taking care of him. This feeling may be guided by the feeling of gratitude to Wipa as part of his feeling rules. Sumet appears to feel neglected by Wipa as Sumet said:

> If she is very interested in me, I feel happy and have a power to fight with my illness...I know she is unable to take care of me closely because she has to work as well. I am OK that she looks after me every day...I do not want to bother her when she works. I just stay at home (line 146-149).

Buddhist beliefs in karma, her role in the family and the influence of neighbours may be Wipa's feeling rules. She realised that she should be willing to support him, but she felt differently as she stated: "I worried about him. Sometimes, he used to hurt my feelings. It is good sense to be responsible for him" (line 90). The way she behaved towards Sumet indicates she may be uncomfortable caring for him. She presented surface acting in order to suppress unpleasant feelings. The excerpt below confirmed these feelings as Wipa indicated:

> It is because I disappoint him. It is also my bad karma…I hope he should support me. He should help me to do housework. I need his encouragement, but he has never done anything (line 57-58)…I have different feelings for him now than I did in the past. It seems like we are distant (line 296).

Data from the series of observations and interviews did not present accounts in relation to deep acting. Although Wipa had strong beliefs in Buddhism and tried to follow Buddhist teaching to calm her emotions and feelings, it seems that she chose to ignore Sumet rather than manage her own feelings to create a more positive

dynamic during caring interactions. For Sumet, the way he talked and behaved in front of Wipa suggested that he was very sensitive. From the account above, it is clear that Sumet's and Wipa's relationship affected their power to manage their inner feelings.

Pair 10: Kamol (brother-stroke survivor) and Usa (older sister-carer)

This observation was arranged for one and half hours before the interview session. The following scene is selected in order to show significant activities between Kamol and Usa.

> Kamol smiled at me while I was walking to him. He sat on the ground as he was fixing his walking stick. I said: "How are you today?" He answered with a little smile: "Good" He led me to the table nearby…We heard engine sounds and he said: "She (Usa) is coming." Usa was riding a motorcycle home. She smiled and asked me: "Have you been here long?" I answered: "Just a few minutes." She nodded and walked inside home. We heard her complaining about a messy home. Kamol said with a sigh: "Every day" I asked him: "Who does she complain to?" He pointed to himself without any emotional expression: "Let it be. However, she is my sister."…Usa came to sit next to Kamol in order to do hand exercise with him. I then moved to a chair nearby.
>
> Usa Have you exercised your hand today?
> Kamol Yes, I just did it in the early morning
> Usa You have to do it regularly. Can you show me how you do?
> Kamol (nods) Yes, I know. (moving his right hand and fingers)
> Usa (frowns and raising her voice) No, you should do it like this (demonstrating)
>
> She spoke of how to do proper exercise with such a loud voice. Kamol tried to imitate how Usa moved her right hand. He frowned and looked at his hand. Usa lowered her voice after looking at Kamol's face. She then did a passive exercise for him. It took time, around ten minutes. At some time in that period, Usa talked about the advantage of taking exercise whereas Kamol gave her nods and said nothing. His eyes expressed thankfulness.
>
> Usa (smiles) Good. We will do it again tomorrow.
> By the way, you do not wash clothes for me. You just only wash your own.
> Kamol (nods) OK
> Usa I do not want to give you a load.
> Did you have lunch yet?
> Kamol Not yet
> Usa Have you cooked rice already?
> Kamol Yes
> Usa I will stir-fry chicken and vegetable for you.
> Kamol (smiles) Thank you so much (Observation, 10/12/11).

At the beginning of this scene Kamol looked comfortable and relaxed at first sight. His manner then changed due to stress when he communicated with his sister. Throughout this scene I found that Kamol did not show any expression of particular emotions in the period of the interaction between him and his sister. It seems that Kamol was very careful of what he said and how he behaved in front of Usa, but on the other hand Usa's emotions were expressed freely. This may be because they had different positions in the family. Usa was the family leader and made money for all family members, whereas Kamol was a family member and unable to work for money since his stroke onset. In addition, she was his oldest sister whom Kamol respected and relied on for help.

The scene illustrates typical emotion work in a stressful situation for Kamol. His feeling rules might connect to the norms of respect for older people and gratitude to a benevolent person, framing Kamol's feeling that he should not feel angry at Usa when she complained. He seemed to try to work on his emotions and feelings and expressed calmness as surface acting. Nevertheless, it appears that his deep acting would also be aroused by the feeling of gratitude to Usa for her help which was presented through his eyes in his expression of thankfulness and through what he said: "Let it be. However, she is my sister." Kamol shared the idea of feeling grateful:

> She (Usa) took care of me when I was unable to move my body. She washed my clothes, fed and cleaned me...She bought good medicine to cure me and also gave me some money... I am not angry at her when she complains about something. It just annoys me (line 163-164)...All she has done is good for me. If I do not have her, I cannot imagine how I would live. She is like my mother, and I know that I cannot live without her (line 169-170).

Although Usa had power over Kamol as seen in the above scene, the way she exercised with him showed goodwill. The norms of sibling relationships and gender roles may shape her feelings as a feeling rule regarding a sense of responsibility. Emotion work was shown as surface acting when she lowered her voice after rebuking him because she disapproved of how he exercised. It appears that Usa knew when Kamol felt stress in a given situation. She then tried to calm him by changing

the topic and offering him lunch. The process of emotion management from inner feelings or deep acting seems connected to her accounts of beliefs about karma and of her best wishes for Kamol including feelings of sympathy. Usa said:

> I think that the life situation will improve if I do good things nowadays (line 147)....I wish him full recovery. He will not be like this (physical limitation). I want him to help himself. He may then work for a living and have his own family…. If he remains like this and stays with me, there is no future for him (line 183-185).

Pair 11: Prasom (son-stroke survivor) and Somjai (mother-carer)

For this pair, I visited their house five times and interviewed Prasom and Somjai two and three times respectively. We met each time for Prasom's interview appointment at a little hut some distance from his house, around 500 metres, whereas I interviewed Somjai at the house. There were only three times out of five that I found them together for a short period. They did not reveal any conflict with each other. On the contrary, I found a lot of love between them. The following scene occurred in the last visit.

> Prasom lay on the sofa in front of the television and was watching a news programme. He looked very relaxed. Somjai was walking around in the house, and I did not exactly know what she was doing. She looked at Prasom every time she passed him, whereas Prasom still concentrated on the programme...Somjai was carrying a dessert from the kitchen. She stopped next to Prasom and served him the dessert. Prasom looked at the dish and then looked up to Somjai's face. He shook his head a few times: "You should not bring it for me. I will take it myself if I need it, or when Sak (Prasom's son) gets back from school, I will ask him to do that." Somjai gave him a little smile: "It is not a big task for me anymore. I just bring it from the kitchen. I am afraid that ants in the kitchen might go up on the dessert if you wait for Sak." Prasom took a deep breath and answered nothing. However, he received the dessert from Somjai. He got back to the television and started eating the dessert. Somjai served him a glass of water and stayed with him for awhile. She then returned to the kitchen (Observation, 24/12/11).

The way Prasom talked and behaved to Somjai in this scene showed that he could not suppress his annoyance when Somjai tried to serve him. He stated during the interview sessions that he did not want his mother to pay so much attention to him.

She was his mother, and he loved her. He did not want to burden her with his problems, as Prasom said:

> In everyday living, I have one thing that I am rather dissatisfied with my mother. For example, when I walk to the fridge for drinking, she reaches there before me and gives me a glass of water. I don't like her to do that (line 72-73)…I want to do it myself. I don't want to bother her…I intend to do all things myself. I think that she tries to serve me everything because she wants to make me more comfortable (line 81-82)…She is not my servant (line 85).

For Prasom's emotion work, it appears that he expressed surface acting in the scene. Prasom listened to Somjai's reason that she was afraid of ants which might go up on the dessert. This reason made him realise that he should not feel annoyed at her. He should thank her for her good intentions. He already knew that he could not stop Somjai trying to please him when he stayed at the house. Therefore, he tried to avoid her by going out. For his feeling rules, the feeling of gratitude to his mother may guide Prasom's decision-making in this situation.

Somjai's emotion work is also illustrated in the scene. She was calm and peaceful in front of Prasom although he expressed his annoyance towards her. The way she smiled and responded to him showed her deep acting, for which her expression was regulated from her deep feelings. Somjai's interview data indicated that Prasom had never made her angry. She realised what Prasom thought about this issue, and she understood him very well. Somjai said:

> He is very nice. He tries not to make himself as a cause of my worries. He is also afraid that I would worry greatly about him (line 24)...He is my son. I am his mother. I take much care of him and make him feel comfortable as much as I can (line 185-186).

The above excerpts present the quality of a mother's love which may frame Somjai's emotions and feelings as her feeling rules.

Pair 12: Mena (wife-stroke survivor) and Thawon (husband-carer)

Mena always stayed at home alone in the daytime because Thawon worked outside almost every day. He would normally come home at midday to have lunch with

Mena. He returned to work after lunch and finished work in the late afternoon. Although Mena could primarily help herself, she still had weakness on the left side of her body. Thawon supported her through practical help when she did her daily routine. The following scene occurred in the afternoon time.

> There was a big table in front of the house and Mena spent most time at this table during the day, i.e. taking a nap, having meals, preparing food and recreation…Mena sat at the big table preparing dinner, while Thawon was picking home-grown vegetables in the backyard...She was looking for something on the table. She called Thawon a few minutes later: "Where are you?" There was no answer from Thawon. She looked moody at that time. She frowned and called him again raising her voice after no reply. "I need some help. Where are you?" Thawon ran fast to Mena, and he looked excited. There were some vegetables in his hand: "What is wrong with you? Are you OK?" Mena nodded her head: "I cannot find a big plate. I need it for a vegetable stir-fry." Thawon sighed: "Do you need the plate now? I am picking up vegetables for a stir-fry. I will find the plate for you after that." Mena answered with a weak smile: "I just want that everything is ready before starting to cook food. I am afraid that you might not find the plate on time." Thawon closed his eyes a few seconds and took a deep breath. "OK. Which one do you want? They then helped each other to find the plate (Observation, 15/12/11).

Mena's anger is noticeable when she frowned and called Thawon again with raised voice. Her emotion changed when she saw Thawon's face. She may feel guilty for causing his worries. She therefore presented a smiling face to him. This scene shows Mena's emotion work as surface acting. She could change her moody face to a smiling face in front of Thawon. The way she gave him her reason why she called him in that way might be because she did not want to increase his worries about her. She knew that she should not feel angry at him in this situation. She should be satisfied with him for what he did. The feeling of gratitude to Thawon for all his help may guide her emotions and feelings as part of her feeling rules. Mena stated her feelings for Thawon during an interview:

> He has behaved well to me since we are married. He is the same (line 102)…He is greatly significant. If I do not have him, how I do I live? He is the one who paid for my cost of living (line 137).

Thawon also presented surface acting. This scene illustrates that he felt dissatisfied with Mena's behaviour (unreasonable shouting). He adjusted his own emotions and

feelings by using surface acting through closing his eyes for a few seconds. He also used bodily deep acting by taking a deep breath in order to suppress his dissatisfaction. He finally decided to make Mena happy by responding to her need. The sense of responsibility as her husband and the family leader may lead his feelings to follow social rules. Furthermore, his experiences may guide his decision in this situation. He stated that there were many times where he experienced dealing with Mena's anger difficult. Thawon raised an example of this issue:

> Sometimes, I get angry back at her when she is angry with me…I can stop this emotion because I think that she does it in that way due to her stresses…I always leave her alone for awhile…We then get back to talk to one another after that (line 57-60).

In summary, this section discussed visible aspects of each participant's emotion work within caring interactions. Regarding all witnessed scenes of emotion management during caring interactions, sampled scenes are selected from various situations arising in everyday lives in order to identify a differentiation between surface acting and deep acting. In these scenes, varied forms of surface and deep acting were shown. Surface acting was demonstrated by an immediate change of the participants' emotional expression during the scenes, whereas deep acting was indicated through environmental influences and circumstances in connection with the participants' own experiences. Furthermore, individual emotion and feeling states in different situations may be guided by different feeling rules that the participants perceived to be operating in a given context.

Data suggest that the feeling of gratitude and the sense of responsibility apparently underlie emotion work performance within different kinds of relationships, i.e. mother-child, sibling and spouse relationships. In the mother-child relationships (pairs 6, 8, 11), participants tended to show deep acting during caring interactions to each other. The quality of love and motherhood may frame their feelings and behaviour. O'Brien (2007) stated that women in motherhood provide care to their children with no expectations in exchange. For children, the cultural construction of respect and gratitude to parents may persuade them to perform deep acting. In sibling and spouse relationships, the performance of emotion work may also be framed by

gender roles, moral and social significance, and the quality of relationships. These contributing factors may be able to reshape their feelings at every stage of caring interactions.

In the following sections 8.3-8.5, these data are discussed through three subthemes of the core theme of this chapter, 'Emotion management'. These are Emotion work as part of daily life; Emotion work as reflection and; Gender differences.

8.3 Emotion work as part of daily life

Emotion work as part of daily life emerges as a subtheme of emotion management. The focus of the following analysis is firmly based on stroke care in the family home, and it confirms that emotion work was intimately involved in stroke survivors' and carers' everyday lives. The observed scenarios discussed earlier in this chapter provide an initial insight into how stroke survivors and carers engaged in emotion work during daily caring interactions. Although these selected scenes of caring interactions between stroke survivor and carer were unique to each pair, they displayed emotions tailored in response to a particular situation. When both survivor and carer felt like a misfit, they tried to manage their own feelings by suppressing undesired elements and expressing feelings which conformed to normative expectations. Sometimes, they sought to control one another's feelings as well.

Visible in the scenes of emotion work strategies of the twelve stroke survivors and carers was surface acting and deep acting (Hochschild 1983). Surface acting was carried out when the individuals hid their real feelings behind a mask of expected emotion (such as smiling when he/she feels angry), and their real feelings remained unchanged (see detail in pairs 1, 2, 4, 5, 7, 9, 10, 11 and 12). Deep acting arose where the individuals altered their inward feelings to create the outward appearance to follow what they judged best to feel (see detail in pairs 1, 2, 3, 4, 6, 8, 10, 11, and 12). Deep acting strategies seemed to be connected with the sense of gratitude and the quality of personal relationship between stroke survivors and carers, and this will

be discussed later in this chapter. However, both strategies were dependent upon the circumstances around what they were dealing with.

Through looking at the purposes of succeeding in emotion work (surface and deep acting) as observed within the scenes, stroke survivors and carers appear to be keen to maintain stable interpersonal relationships with the other. Two convincing reasons based on the sample scenes can clearly be identified. Firstly, they attempted to avoid having an argument over the particular situation. Often, an emotional issue which occurred during caring interactions could be predicted to bring stroke survivors and carers into conflict. They tried to stop the potential conflict at hand by regulating their own emotions and feelings. For example, Somchat (carer, pair 1) suppressed his anger towards Somsri and spoke to her in a friendly manner. Similarly, Thawon (carer, pair 12) chose to oblige Mena by performing certain tasks when she wanted him to do many tasks at the same time although he was busy. Karun (stroke survivor, pair 5) kept silent instead of responding angrily to Pranee after she rebuked him. Secondly, they tried to motivate one another's emotions and feelings at hand. For example, Supa (carer, pair 2) calmed Pichai when he was angry by apologising and speaking politely to him. Pracha (carer, pair 8) calmed himself to prevent Duangjai from becoming stressed. Somjai (carer, pair 11) stopped Prasom from feeling more dissatisfied by giving him a reason why she acted in that manner.

These scenes identify the emotion work existing in stroke survivors' and carers' day-to-day activities. Stroke survivors and carers engaged in emotion work in various ways. They had their own strategies to achieve emotion work in order to respond to their feelings appropriately in a given situation. Furthermore, it appears that individuals became both a provider and a receiver at the same time during the process of emotion work. Individuals provided the expression of their feeling to the other, while they received the other's emotional response as a reflection. The result of this process may or may not achieve their ambition, however at least the individuals could sustain the personal relationship with the other and continue the daily routines of caring interactions. The individuals may store personal knowledge derived from a particular situation in order to utilise it next time as their own reflexive account.

From the interview data, none of the participants discounted emotional issues and emotion work from the experience of their caring interactions in the routine of everyday life. According to carers' experiences, all carer participants identified that the management of emotions were inevitably integral to their caring role. They tended to manage their emotions and feelings in order to continue their role and live as normal. The underlying significance of achieving emotion work within carers' everyday lives was shown through how they thought about stroke survivors and their current life situation. As Pracha (carer, pair 8) described, for example:

> I don't care whether or not she (his mother) has a full recovery. I don't think about tomorrow or next month. I go beyond that point. I am interested in how to make her happy about every day (line 175).

In such a situation a reduction in any source of emotional harm to his mother was important for Pracha as his basic idea. He was keen to maintain his mother's pleasant feeling and tended not to display much emotion in front of her. Somjai (carer, pair 11) described her key reason for the provision of emotional support for her son:

> I really want to do all things for him (her son). I don't want him to worry. Because he has difficulty walking, I should serve him more than ever and every day (line 13).

For this reason Somjai constantly provided good care for her son including effort not to cause him unpleasant feelings. The relationship is based on their existing roles which generated feeling rules related to family and gender expectations. Supa (carer, pair 2) added the same idea: "No matter what he (her husband) does, I will please him first" (line 187). To satisfy her husband appeared to be Supa's first priority. It was clear that the provision of emotional support became an important aspect of carers' routine activities for taking care of stroke survivors. Similarly, Somchat (carer, pair 1) claimed that supporting his wife's emotional well-being merged with his everyday routine activities:

> I always make her happy. It becomes habitual (line 154)...We will have a friendly chat and watch the television together after having dinner. I use this period to enhance our relationship and to reduce her stresses (line 298-299).

Here Somchat indicated his own methods for maintaining his wife's pleasurable feelings which suited him best and his wife's need. Somsong (carer, pair 3) spoke of her feeling of stress during carrying out emotional support:

> I don't rebuke him and don't make him stressed out. I wouldn't express how stressed I am (line 61-62)…Every day I must help him. I must encourage his will to live (line 139)…We like to have a relaxed talk at bedtime. We always talk about work, family and our son (line 167).

Many carers described various ways of reducing stoke survivors' stresses and unpleasantness. Although carers felt able to provide emotional support, it is also apparent that the intention to reduce the emotional burden on stroke survivors made quite an emotional impact on carers themselves. Pranee (pair 5) revealed her feelings and gave examples of her attempts at emotion management:

> I soothe him when he feels down, although I put so much pressure on myself. It is too heavy. I have to hide my stresses (line 19)...I would like to make him happy and cheerful at any time (line 232).

Carers' sentiments firmly indicated that they recognised stroke survivors' emotional problems following stroke. The carers were likely to help stroke survivors face up to the problems and maintain their own emotional state. Those comments described above show the high degree of involvement carers had in providing some emotional support for stroke survivors. It seems that carers' emotion work was invested in trying to help stroke survivors with the emotional burden of life's difficulties. These carers' views of attempting to do emotion work and of providing emotional support seem evident in carers' commitment to persisting in their caring role. The commitment to care for stroke survivors with love and with kind feelings was palpable in carers' efforts to sustain the caring role.

From stroke survivors' accounts, all stroke survivors reported the experiences of both physical and emotional burdens. To deal with the impact of having physical limitations following stroke, particularly emotional burden, stroke survivors had personal methods to soften the impact. For example, Pichai (pair 2), Kamol (pair 10) and Prasom (pair 11) liked to visit and have conversations with neighbours. Putting

on make-up was a way Duangjai (pair 8) used to reduce her stress. Umpa (pair 6) always listened to Buddhist teachings to calm herself down. Somsri (pair 1) loved gardening when she felt bored. The methods included chanting, watching television, listening to music, playing with children, drinking coffee, smoking, reading newspapers and magazines, taking a nap and strolling. However, these methods seemed only to provide them with temporary relief to their problems.

The excerpts below indicate that many stroke survivors employed their own way to cope with a difficult situation in their lives:

> I don't think about my limitations any more. I know that I cannot move my legs as I used to do, so I accept that. I try to make a pleasant feeling (Somsri, line 19).
>
> I calm myself down when I am in distress. I just remind myself that I am not the same (line 47)…My feelings vary from day to day. I cannot explain why I feel like that (Karun, line 237).
>
> I try not to think of my illness. I try not to stress over it. I try to think calm thoughts (Nisa, line 20).
>
> I am resigned to losing my ability. I have to accept it (line 50)…I try to make myself feel positive by not immersing myself in unpleasant issues (Sumet, line 151).
>
> Let it be. Don't think so much. I take time to accustom myself to accept the current situation (Kamol, line 151).

As illustrated in the above quotes, stroke survivors' sentiments present their coping strategies which were a conscious effort to feel better. These strategies seemed to be undertaken for protecting themselves from physical and emotional burdens following stroke and unpleasant situations which might make them feel low. In fact, stroke survivors inevitably had encounters with emotional distress in everyday living. Therefore, they tried to generate positive feeling by gaining acceptance of their current life situation. It appears that the approach aimed not only prevent current feelings, but also minimise the likelihood of having unpleasant feelings in the future.

Stroke survivors realised that they still depended heavily on their carer for living. Every day all stroke survivors tried to maintain a stable interpersonal relationship with carers through the reciprocity of responsibility for household tasks and engaging in emotion work. In respect of the former, domestic work is relevant to traditional roles. Domestic or household chores are considered as characteristically women's work (James 1992; Pfeffer 2010). I found that female stroke survivors tried to maintain their responsibility for household tasks, whereas the sharing of household responsibility was claimed by a few male stroke survivors such as Sumet (pair 9) and Kamol (pair 10), although they hardly ever did housework before. Pichai (pair 2) and his wife had a reversal of domestic roles. Similarly, Prasit (pair 3) attempted to do housework, while his wife was working outside. However, three men (i.e. Samart, Karun and Prasom) did not take on any responsibilities for such tasks by reason of not being men's work. This issue will be discussed further in the section on gender differences.

All stroke survivors described a wide range of emotion work they had experienced. For example, Pichai (pair 2) sometimes allowed Supa to blame him for his behaviour although he felt dissatisfied. Nisa (pair 7) remained silent when Prakit hurt her with his unfriendly manner or by saying hard words. Sumet (pair 9) tried to change his feeling to calm himself when Wipa made him feel upset or unhappy. Kamol (pair 10) always kept his stresses or annoyance inside when Usa complained about him or someone-else, and he did not allow her to know what he felt. Prasom (Pair 11) chose to go away from Somjai rather than expressing his dissatisfaction in front of her when she tried to serve him. This evidence, how stroke survivors engaged in emotion work, linked with life's daily routine.

In summary, the points raised throughout this section reveal that the emotion work involved in caring among stroke survivors and carers is an important part of their common situation. Engaging in emotion work is likely to be a demanding task in everyday living, especially during caring interactions. Aspects of emotion work appear to be necessary to completing physical tasks. This involved understanding that emotion work may be the outcome of carrying out those physical care routines.

Stroke survivors and carers employed emotion work strategies as part of sustaining a stable relationship between them. By attending to the intrapersonal control of emotions, stroke survivors were able to cope with their own problems. Most stroke survivors tried to reduce physical burdens on carers by sharing household tasks. This appears to be the way they expressed thanks and returned the feeling of being grateful to carers. In the same way, the quality of gratitude seems to relate closely to carers' persistence in being a main carer. This will be discussed in the following section.

8.4 Emotion work as reflection

Emotion work as reflection emerges as a subtheme relating to stroke survivors' and carers' experiences with emotional difficulties during everyday living. Amble stated that "the word reflection means back through; in the cognitive context this means the mind bending back to itself, in other words, re-thinking how one thinks in order to examine the construction or reconstruction of a mental map or schema" (Amble 2012: 266). Mälkki (2012) found that individuals could conceptualise new meaning from the context of a life-event crisis through using the process of reflection. Here, reflection appears as a way individuals utilise previous personal experiences and the underlying significance of associated issues for achieving emotion work. The process of how they developed their skills and what contributing factors influenced reflection in making emotion work will be revealed. The complex interplay between the process of engaging in emotion work and reflection is the focus of data analysis. This section touches on two points. The first point shows how stroke survivors and carers learnt to succeed in emotion work and how they themselves prepared for coping with various situations. The second point discusses what feeling rules shaped their decision-making and emotional response in order to achieve emotion work.

8.4.1 Life experiences

As indicated in section 8.3, stroke survivor and carer participants described how emotion work arose in their everyday routines. Undertaking caring interactions was also very much a matter of feeling. This means that the participants have been

accumulating a great amount of experience in emotion work which might influence their thinking, understanding or behaviour subsequently. In fact, having a stroke and being a main carer of a stroke survivor had made many changes to various aspects of stroke survivors' and carers' lives. Some stroke survivor had accepted that their mood changed significantly after the stroke event as Prasom (pair 11) explained:

> Normally, I am not a kind of person who gets angry easily. I become more irritable than usual following stroke. I am always annoyed with being unable to come up to my expectations (line 158-159).

Prasom realised the changes in his mood resulted from having physical limitations following stroke. Other stroke survivors raised similar changes. Pichai (pair 2) described that he was a quick-tempered person, especially when he got drunk. He became much more peaceful after having a stroke. Sumet (pair 9) said:

> I used to be a quiet man. I preferred listening to, talking to other people. I always smiled and laughed during joining in a conversation (line 150). Nowadays, my mood becomes different. I am rather bad-tempered (line 160).

Similarly, Karun (pair 5) mentioned that he was very touchy in comparison to the past. Here it was not only an alteration to the stroke survivors' mood, but also the fact that it produced effects on carers as Pranee (Karun's wife) described how her feelings were affected by the change in Karun' s mood:

Pranee	I take care of him every day. Sometimes, I am so bored, but I think I have to accept that because it (her husband having a stroke) already happened.
Maturada	What do you do when you feel bored?
Pranee	I don't do things that much. I just talk to him. I soothe him when he feels down, although I put so much pressure on myself. It is too heavy. I have to hide my stresses (almost crying). I always do like this.
Maturada	Why do you do in that way?
Parnee	I hide my stress because I want to stop him from thinking. He will get a splitting headache when he does serious thinking.
Maturada	Does he always think so much?
Pranee	He got stuck on worrying after having a stroke. He often worries about things which are outside his control.
Matudara	How do you know that?

Pranee I know because he shows me. He used to scream with stresses and beg for a painkiller. Once I have found how much he was stressed out I decide to keep my feelings and not show my stresses in front of him. I always remain silent and keep myself calm under any distress.

Maturada How do you calm yourself?

Pranee I talk to myself and try to stop thinking so much. I drive myself into a peaceful mind. I keep talking to myself to stop worrying. I realised that thinking so much makes me unhappy. I used to do this technique to calm myself down when I got an operation on my head due to a brain tumour many years ago. It is very effective (line 16-26).

Pranee indicated that she was willing to be Karun's carer and accepted any change in her life situation. She also gave an explanation of strain caused by Karun. It appears that she was able to live under strain as a result of undertaking emotion work as deep acting strategy. She suppressed her inner feeling and expressed appropriate feeling in front of Karun. Pranee's account pointed to three aspects of her emotion work. Firstly, achieving emotion work was an effective way to solve her emotional problems as a coping strategy. Secondly, the way of doing emotion work was still very present in her account. She would remind herself whenever she wanted to make herself calm down. Thirdly, personal life experiences were an advantage, giving a resource which she learnt to engage in emotion work. She accumulated the experience of important life events (having a brain operation, becoming a main carer of a stroke survivor) to inform her way of succeeding in emotion work. When she faced a similar situation, she could reconstruct how to succeed in emotion work to reduce emotional difficulties. This suggests that individuals learnt to achieve emotion work through personal life experiences, and the experiences of emotion work were collected and available for using next time. The following quotations demonstrate how carers reflected on their experiences of emotion work. Somchat and Naree used the method of avoiding confrontation, and creating positive thinking and calmness were used by Wipa as they each describe here:

> When I saw her crying, I would leave her alone. It was because she would make more crying if I stayed with her. So, I just went away and left her alone. She stopped crying finally (line 70)...I knew that she was able to calm herself (line 73)...I let her spend her time around half an hour or an hour. She returned to normal and had stopped crying when I got back (Somchat, line 75-76).

> Now, I have no problem to deal with her when she is out of sorts. If she was cranky, I would remain silent. If she tried to talk to me, I would not talk back to her. It will be fine when we stop talking. We will return to talk to each other when we cease to be angry (Naree, line 80-81).
>
> I follow Buddhist teachings. I also think about someone who has a worse life than me. I keep thinking about that every day. I can make myself calm when I feel angry (Wipa, line 219-220).

These accounts indicate how reflection and the experiences of emotion work brought them to understand how to deal with not only their own feelings but also one another's feelings in a given situation. They concentrated on and used all their experiences to regulate their feelings and to present appropriate acting. It seems that these methods they used for solution were examined through their practices in everyday lives as they were learning by doing. Although they might experience a failure or success in undertaking emotion work, they automatically learnt and improved their skills. Those experiences were collected as individual tacit knowledge, and the knowledge was utilised for conquering unpleasant feelings in demanding situations.

This further example describes a comparison of different experiences of emotion work undertaken by pairs. Nisa (wife-stroke survivor) and Prakit (husband-carer, pair 7) gave reasons why they did not pay attention to each other despite living together:

> I realise that he did a good thing for me as my carer, whether or not he was willing to take care of me (line 273)...while at the time I was unable to move the left side of my body, I just stayed at home most of the time. I had a lot to put up with from him. I kept silent when I felt angry, upset or stressed out. He did not know what I felt. I intended to let him know I was fine for all things he had done to me…I always act like this because I know that I have to depend on him for living (Nisa, line 276-277).
>
> She is unfeeling and distant. She gives me the cold shoulder (line 143)…For example, I got severe abdominal pains due to appendicitis. She already knew I was suffering from pains, but she had never asked me about that. She sat near to me, but she did not help me anymore. My increasing pain did not interest her. I had to call my brother to send me to hospital. Now, I am downhearted to do things for her. I tried to neglect her and do nothing with her (Prakit, line 151-152).

Excerpts above illustrate Nisa's and Prakit's accounts in relation to emotion work in the typically stressful situation of a climate of unpleasantness. Their interaction appeared to be an exchange of distress. They lived under pressure and in an emotionally charged atmosphere. While caring interactions between them were a trigger for revisiting their painful personal experiences of conflict, Nisa and Prakit chose to hide real feeling and behaved in unfriendly ways towards each other. The power of their conflict and personal emotional experiences influenced them to engage in emotion work in this way. It seems to be the only way for them to continue living with their marital conflict. However, Nisa said, "I realise that he did a good thing for me as my carer." The feeling of gratitude to Prakit may guide her not to harm him too much.

8.4.2 Feeling rules

Personal life experiences were discussed as a contributing factor of reflection which participants used for learning how to cope with emotional difficulties and to achieve a stable emotional tempo through emotion work. Feeling rules emerge as another factor which influences stroke survivors' and carers' awareness of engaging in emotion work. Hochschild (1983) uses the term 'feeling rules' to describe beliefs about emotion norms in societies which individuals should experience and be supposed to feel in a particular situation. The process of emotion work happens when individuals work on their feelings to suit these norms in order to express their emotional state in an appropriate way in public. The power of feeling rules may be influenced by broad cultural and social norms which are important for individuals' decision-making to undertake emotion work during caring interactions.

The feeling of gratitude emerged strongly from the interviews in this study. Both stroke survivors and carers always connected their sense of gratitude with basic reasons for their decision-making in everyday living. Despite having various kinds of relationships described in this study, i.e. husband-wife, mother-child and sibling relationships, the relationships were presented as a dynamic force with the individuals having a lot of influence over each other within the context of each pair. The quality

of their relationship was not only between providers and receivers, but also between parent and child or between spouses or between siblings in which each pair gave priority to each other.

The sense of gratitude, in which people should express thanks or return the favour to a person who has done a good deed or been kind to them, seems to be a feeling rule described by participants. In respect of each kind of relationship, participants' accounts expressed the reciprocity of kindness. All stroke survivors were grateful to carers for all their help. Most stroke survivors sought a way to reduce carers' physical burden. They tried to undertake emotion work to increase carers' emotional well-being as well. For carers, they repaid good turns to stroke survivors through being a main carer and kept this feeling throughout undertaking their role. It appears that the feeling of gratitude is certainly preserved in participants' minds, and the way participants engage in emotion work is to repay the favour to the other.

The full details of how stroke survivors and carers had feelings of gratitude is discussed in 6.5.2 (Gratitude to carers) and in 7.2.3 (Reciprocating kindness). Through these ideas, the sense of gratitude seems to be affected by the tradition of Thai family and culture. Buddhism also has an effect on the way of thinking about gratitude among all participants (Kongsuwan et al. 2012). In Thai society, Buddhism has been firmly linked with cultural expression and Thai beliefs (Taylor 2005) and "is recognised as a key social and political institution" (Limanonda 1995: 68).

Thai children are instilled with ideas of gratitude from a very young age. Appropriate respect for parents, siblings, relatives, teachers, monks and older people is fostered in them. The site where they learn about their social place in the societal hierarchy is the family (Pinyuchon and Gray 1997: 212). This remains a classic study which describes the relationships among members in the Thai family as very close and specific (Thamavitt and Golden 1954). Thai society is a relatively hierarchical social structure (Fuller et al. 2004). In everyday lives, children are encouraged to show gratitude for their parents, grandparents and benefactors. One of the most important responsibilities for children is to look after their parents and/or grandparents in their

very old age as a way of expressing their gratitude (Limanonda 1995). This idea of expressing gratitude is also regarded as doing good things (Bun) in Buddhist beliefs and practices.

Examples of the feeling of gratitude occurred in the parent-child relationship in the stroke data. In Pair 6, Umpa (daughter-stroke survivor) appreciated Naree (mother-carer) for taking care of her. At the same time she was ashamed of herself because she should take care of Naree rather than Naree look after her. For Naree, she expressed the quality of love as a mother. Naree appears disappointed about the stroke event because she expected that Umpa would look after her when she took her retirement. Similarly, Prasom (pair 11) felt gratitude to his mother (Somjai) for her kindness. He felt so guilty about creating worries for her. Somjai had strong feelings for Prasom. Love as a mother and the feeling of gratitude for financial support from him so far made Somjai upset when she was looking at Prasom. In pair 8, Pracha (son-carer) dedicated his life to take care of his mother due to the sense of his gratitude. Duangjai (mother-stroke survivor) thought that she was very lucky to have a good son. She also felt shame that her son was unable to have his own life.

The feeling of gratitude occurred in the relationship between siblings. Usa (pair 10) volunteered to take care of Kamol (her brother) because she wanted to keep her promise to her parents (to look after all siblings). She was also reminded of gratitude owing for good things that Kamol had done for her. Kamol himself felt overwhelmed by Usa's kindness and tried to express thanks to her by undertaking emotion work. The gratitude between spouses was also illustrated during interviews. Stroke survivors and carers showed their thankfulness to each other.

The sense of responsibility emerges strongly as a feeling rule in stroke survivors' and carers' emotion work regarding their roles and moral stance in Thai culture. There were various roles within the family such as family leader, family member, father and/or husband, mother and/or wife, son and/or brother and daughter and/or sister. These roles brought a huge sense of responsibility. It was evident that survivors and carers had a responsibility to perform their own roles. They could continue living as

usual; their routine activities could be adapted to suit individuals' situations following stroke. Data suggest that stroke survivors made the effort to recover from stroke and to retain their former role in the family. These activities appear to influence their emotion work achievement in everyday living.

For carers, the sense of responsibility appears to be associated with the labour of love. The labour of love involves in caring relationships influencing physical and emotional aspects of caring (O'Riordan et al. 2010). Caring for someone is strongly associated with feelings and emotions (Graham 1983). According to Naree (pair 6) and Somjai (pair 11), the roles of mother and carer intermingle to protect their children (stroke survivors) from the uncertainty surrounding their lives. Motherhood and caring are seen as the central roles of women (Pilcher 1999). Mothers understand care work as love, especially emotional care (O'Brien 2007). The parent-child relationship is a primary care relationship involving a depth of emotional engagement (Lynch 2007). The caring relationships are built "as symbolic bonds" (Graham 1983: 16). Similarly, a blend of the caring role and the role of husband, wife, son, daughter or others appears to be underlain by the labour of love. They appear to engage in emotion work in order to shield their loves from undesirable feelings.

In summary, emotion work enacted within caring interactions between stroke survivors and carers is accomplished through two significant factors, personal life experiences and their own feeling rules. Personal life experiences become a source of how to deal with uncomfortable feelings, while feeling rules, the feeling of gratitude and the sense of responsibility, become a matter of self-awareness when individuals were facing an emotional misfit in a particular situation. The integration of these two factors influences individuals to reflect on achieving emotion work. The next section will discuss gender differences regarding emotion work.

8.5 Gender differences

Stroke is a life-threatening illness which led to a turning point in stroke survivors' and carers' lives. The effects of stroke radiate out across their families as well. This subtheme focuses on participants' accounts of how the stroke affected them in relation to the differences between sexes and what the post-stroke period meant for them regarding a sense of their roles in the family and emotion work. Different cultures contribute to differences in emotional experiences and regulations (Davis et al. 2012; Fischer and Manstead 2000; Kwon et al. 2013). Social structure has a strong influence on gender-normative roles. Men tend to occupy the role of provider, and women are more likely to occupy the role of carer (Brown and Diekman 2010). Gendered practices in the family are identified as under the influence of culture, economic and political circumstances (Chapman 2004). Fuller et al. (2004) found that Thai married men have higher psychological well-being than married women. Therefore, the significance of gender differences in the family deserves to be presented separately.

For this study, the majority of participants' family structures were nuclear families, i.e. for ten of twelve pairs. All of these families lived nearby to their parents and/or other relatives. According to the participants, the main occupation was farming. Most male participants had two jobs, as farmers and labourers. Some female participants reported that they went to work as construction labourers, factory workers and civil servants sometimes, but they always received lower payment than men (Mills 2005).

Seven of twelve stroke survivors were male. Eight of twelve carers were female, and five of eight female carers were spouses of male stroke survivors. The changes in gender roles were an effect of stroke on families. Gender roles in rural Thai families, which are a patriarchal (Fuller et al. 2004), can be reversed especially in the case of male stroke survivors who were provided care by female carers. All male survivors described change in the man's role in the family due to stroke. In Prasit's words:

> My wife mainly stayed at home to look after our son and to do housework. I normally worked in construction. After the stroke event, she goes out to work

> as a construction labourer, while I am at home to do housework instead (line 126-127)... I feel sorry for her. She has never been out to work without me (line 138).

Karun (pair 5), for example, said regarding the same issue: “I care about her because my wife has to work alone in the field” (line 188). Prasit’s and Karun’s accounts show a link between their abilities to work, their wife’s new position in employment and a feeling of concern. They indicate the male role as family leader who made the main income of the family, and they presented a worried expression for being unable to take the same role as before. In such a situation the stroke led to a change of roles in the family to its opposite. As Sumet (pair 9) said:

> Now, she (his wife) is a person who earns a family living, whereas I stay at home and rehabilitate my body...I am unable to do jobs anymore. She works as a cleaner to make money for household expenses. I know that I cannot help her to work that much. I just help her to do some housework (line 34-35).

Sumet described changes in his lifestyle and responsibility in the family. He was concerned at the change but seemed to accept the situation. He learnt to do household tasks despite having no experience in doing housework. Previously, Sumet worked as a lorry driver in Bangkok and earned a good salary, whereas his wife was a housewife. He sent her money for living and savings. His role in the family was changed following stroke. His wife took up the role of earning a living for the family instead. It appears that working and earning money were very important to indicate the status of family leader, and the effects of the stroke on the role of gender in the family highlighted differences from before.

Some male stroke survivors talked about a change of power across the whole family following stroke. Karun (pair 5) said that his son behaved more stubbornly than ever and did not obey him since he had a stroke. Similarly, Samart (pair 4) claimed that his son and daughter had less respect for him than for his wife. Samart added another aspect to his strong feeling on this issue. He described how he normally gave some money to his daughter when she and her child came to visit him. He looked really upset when he talked about his daughter who had not visited him since the early stage of stroke. Here is what he said to his daughter on her latest visit: “My dear

Siree, I have no money to give you because now I cannot do any jobs" (line 129). It seems that a decrease in status among family members was clearly illustrated through male survivor participants who had been in charge of the family. Similarly, Kamol (pair 10) referred to his power over his wife and the status of his relationship with her:

> Let her (his wife) go. I didn't have a power to dissuade her from leaving. I just let her leave to have her own life (line 83-84).

He said that he and his wife had a five-year happy marriage. His wife decided to leave him two months after the stroke. He felt very sad to let her go, but he did not blame her for going away. He realised that he had lost the power to keep her with him because he could not look after her as a husband and a family leader any more.

Looking through the female lens, most female stroke survivors raised the issue of missing their responsibilities as a wife. A key issue is sexuality. For example, Somsri (pair 1) expressed feelings towards her husband. In her words "If he wants to leave me, or if he wants to have a second wife, I will let him do that" (line 114). Somsri's account showed her acceptance of inability to have sexual intercourse, and indeed she had discovered that her husband had an affair with a married woman, whereas she was bedridden. She confronted her strong feeling about this issue and accepted it as her fault. Somsri explained her reasons for that account:

> I am unable to blame him for having an affair because I cannot have intercourse with him. He goes somewhere to have it and comes back home every day. He has never spent all night long with someone (line 229-230).

Umpa (pair 8) raised a similar issue, as she had separated from her husband six months following stroke. She was around twenty-three years old at that time. Although she said that her life was going well without him, she looked hurt by having a broken family and wished to avoid talking about it. She affirmed her intention not to begin any new relationship with anyone. It appears that Somsri and Umpa felt very upset about this issue and suffered in silence.

Furthermore, inability to carry out previous responsibilities appears to be a big concern for some female survivors and causes them to feel a range of emotions. For example, Duangjai (pair 8) described that she was a housewife and also earned some money by working in a part-time job as an insurer because she loved to talk with people. Duangjai stopped doing everything and spent most of the time in bed following stroke. The issue of being unable to do the same things due to stroke provoked stress and loss of confidence. Similarly, Nisa (pair 7) expressed a feeling of being disappointed when she talked about her life affected by stroke:

> I tried very hard throughout many years to open up a small local shop to trade in hot food in Nakhon Prathom Province...I could run my business only one year, and the shop was closed because of stroke (line 74-75).

Mena (pair 12) said that her jobs were not only doing housework, but also working with her husband in the corn field. Due to the stroke, she could not do some household tasks such as washing clothes, tidying the house and cutting the grass. She was unable to work outside as well. Mena added another point with regard to her changing role following stroke:

> I let him (her husband) make all decisions alone...Sometimes I agree with him. There are many times that I disagree with what he thinks. I just stay silent and let him go on. I do it in this way because he used to blame me for making wrong decisions. He always said that his thoughts are better than my ones (line 139-140)

Here Mena expressed a sense of loss in her responsibilities in the family. Before the stroke event, she and her husband worked and thought through all decisions shoulder to shoulder throughout thirty years of marriage. Stroke affected her life, changing the way of living and being, and she appeared to suffer from those issues.

From the carers' perspectives, I can refer to the four male and eight female carers in this study. All male carers expressed a sense of responsibility to undertake the caring role, whereas most female carers stated that the stroke event required them to play both caring role and the role of making money for family living. Although caring had been assumed as women's work (Fuller 2004; Parks 2010), female carers tried hard

to balance the quality of domestic life and work. It appears that all carers learnt how to care for and to live with disabled people in daily living.

A further finding to support the idea of care work as part of women's role is that the four male carers who looked after female stroke survivors took on this role because there was no woman in the family, and/or women in the family were really not suitable for this work. Each male carer stated that he had at least one woman who came to his assistance. Somchat (pair 1) had his wife's two older sisters to assist him when he did care work for his wife. Prakit (pair 7) explained that his wife's youngest sister looked after his wife when he worked outside, and Thawon (pair 12) worked on his cornfield, and he received some help from his wife's younger sister to take care of his wife when he was out. In pair 8, Pracha's older sister took care of her mother when she came back from work. This suggests that women seemed to have a duty to take care of a stroke survivor who is a family member or relative due to the traditional way of life and female role characteristics.

There is a large volume of published studies describing the role of women in care responsibilities. Women have gradually entered the workforce while combining paid work with domestic duties. The caring role for family members still belongs to them (Baker 2001b; Garey and Hansen 2011; Mills 2005). Hochschild (1989) noted that women always have two main areas of work, outside and inside the home. The first refers to paid employment, and the latter to work which women do at home, i.e. household chores and taking care of family members. Songwathana (2001) studied women's role in the traditional Thai family where Acquired Immune Deficiency Syndrome (AIDS) occurred. She found that married women reported that caring for husbands with AIDS and for children were their main responsibilities, and these responsibilities would transfer to their mother or husband's mother when these women died. Muecke (2001) claimed that most frequent volunteers for care work at home in northern Thai families were mothers, wives, grandmothers and sisters in descending order. It implies that women are positioned as primary carers in the family home where care work is considered part of their duty.

There is a positive view relating to the impact of the stroke on carers, although the post-stroke trajectory led to the dilemma of tackling long-term changes. Supa (pair 2) and Pranee (pair 5) were the two carers who raised this topic. For Supa, she stated that she felt sad for her husband who had lost the ability to do things due to stroke, and considerable increase in her responsibilities in the family caused her stress. However, she felt really good on a reflective view regarding how she derived benefit from the stroke event:

> I have felt more safe since he (her husband) had a stroke…He cannot hurt me, (laughing) and I do not worry about this issue anymore (line 113-114)...It is no more stress for that. Now, I suffer less stress than before. In the past, drinking alcohol caused him to behave badly. Every evening I felt stressed out because I knew that I would get hurt. I had been physically abused by him almost every day (Supa, line 119-120).

Pranee expressed similar feelings. Sometimes, satisfaction became part of her feelings after undertaking the caring role. Pranee's feelings were shown through the following excerpt:

> The experience of stresses made me feel unhappy. I am now happy about that he (her husband) stays at home instead of going out drinking with his friends every night as before, but I am so tired of taking care of him all the time (line 243-244)…Honestly, I am happier than the past when he kept on going out for drinking. In that period of his life when he was drinking, he didn't care about what I felt (line 246).

The stroke event encompassed two contrasting feelings in Pranee's accounts. It was true that she suffered from taking the role of carer due to tiredness. At the same time she felt satisfied with the disappearance of loneliness because her suffering from being neglected was over. During the interviewing around this topic, Pranee showed the engagement of her emotion work. She may well realise that she should feel sympathetic rather than being satisfied with her husband's fate. She tried to give adequate reasons for the feeling of satisfaction about the stroke event to justify her feeling this way.

The nature of gender appears to underlie the different beliefs and roles among men and women within the family. Kritcharoen et al. (2005) studied gender issues within

the family context of 97 Thai female patients and their partners following treatment for cervical cancer. They found that there are major behavioural changes in sex roles and a reduction of sexual intercourse, while gender power relationships were reported as having minor changes. In my study, I found evidence that stroke survivors and carers reported changes in their roles and gender power within the family. The majority of female stroke survivors still did the housework. They tended to undertake household tasks and engage in role-congruent behaviour (Brown and Diekman 2010), despite having limits on resuming their roles following stroke. However, significant changes' in gender power were reported; more men than women described change in power in the family. For carers, men and women assumed additional responsibilities in the family. Apart from taking care of a stroke survivor, men engaged in household tasks, while women were in the labour force to earn income.

As demonstrated through the vignettes of caring interactions, it is evident that female participants tended to recognise signs of the other's and their own undesirable feelings in a particular situation and to engage in emotion work more strongly than males. For example, Supa (wife-carer, pair 2) knew when Pichai (husband-stroke survivor) was dissatisfied with her manner, and she regulated her feeling immediately. At the same time Pichai held the feeling of anger towards Supa, and his feeling was controlled later on. Similarly, Somjai (mother-carer, pair 11) gave Prason (son-stroke survivor) a weak smile instantly when she realised the annoyance in his face and voice. Prasom was unable to stop his undesirable feeling at that time. He could regulate his annoyance after taking a deep breath. This is also true of women who are stroke survivors. Somsri (wife-stroke survivor, pair 1), for example, fell silent when Somchat (husband-carer) got angry with her and raised his voice. Somchat would calm himself down after noticing Somsri's silence. It appears that women may bring the memory of undesirable feelings in any given situation better than men do. Wang (2013) found that women are more likely than men to remember everyday episodic events and accuracy at recall. More women than men may attend to the information in greater detail including remembering emotion intensity during an ongoing event.

Emotion work continues to be regarded as vital to stroke survivors and carers for maintaining interpersonal relationships between them. The process of emotion work is an integral part of the culture of being together in the family home. Fischer and Manstead (2000) stated that the difference between male and female roles is not the main cause of emotional differences. However, in the current study I found that a differentiation of gender roles based on tradition and their backgrounds affected stroke survivors' and carers' underlying reasons for engaging in emotion work in day-to-day life. Women's emotion work was significantly associated with their feeling of gratitude, especially when men shared the division of household labour and took the caring role, while the sense of responsibility apparently underlay men's accounts.

Although women are seen as the emotional stereotype more than men are (Brody and Hall 2008), I found evidence that there was equality of undertaking emotion work in everyday living and no difference between male and female stroke survivors and carers in using emotion work strategies. The same strategies were reported as used for regulating their own feelings in a given situation. For example, Somchat (husband-carer, pair 1) and Naree (mother-carer, pair 6) used a method of avoiding confrontation when they were faced with an undesirable feeling. Chanting was utilised by Karun (husband-survivor, pair 5), Duangjai (mother-survivor, pair 8) and Wipa (wife-carer, pair 9). It implies that there are no distinct male and female styles of emotion work.

In summary, the subtheme of gender differences focuses on gender roles in rural Thai families and the acknowledgement of the effects of stroke on stroke survivors and their carers through the gender lens. The findings reveal emotional experiences and the influence of gender differences on stroke survivors' and carers' emotion work in the families. Rural Thai families are familiar with gender roles within the patriarchal structure. Both sexes showed the strong commitment to undertake not only previous roles as mother, child, husband, wife, sister and brother, but also more recent roles following stroke as stroke survivor and carer. However, women tend to engage in emotion work quicker than men. Emotion work strategies were found to

have gender similarities. Stroke survivors and their carers are keen to accumulate their life experiences for managing physical and emotional issues to establish everyday routine lives.

8.6 Conclusion

Emotion management during caring interactions has been developed as a core theme in order to understand the nature of emotion work among Thai stroke survivors and carers. The existence of stroke survivors' and carers' emotion work while undertaking care tasks is illustrated through observational data including data from interviews and field notes. The visibility of engaging in emotion work is discussed as part of daily routine lives. The achievement of their emotion work is influenced by the links between individual life experiences, the use of reflection and the quality of feeling rules. Differences between men and women in terms of gender roles and engaging in emotion work are made explicit. Men and women use similar strategies to manage their emotions in any given situation. The importance of emotion work is illustrated as stroke survivors' and carers' desire for compromise in their daily routines.

This chapter aims to identify and make visible the process of doing emotion work involved in caring interactions between stroke survivors and carers. At a practical level, all stroke survivors and carers showed how they felt and what way they suppressed and expressed their emotions and feelings during caring interactions. Emotion work was accepted and valued as integral to an everyday trajectory of caring which they worked through. Stroke survivors and carers were also able to create their own way of achieving emotion work in a given situation.

The basis for feeling rules in this study is provided by social guidelines for private settings. Stroke survivors' and carers' feeling rules were connected with Thai culture, religious expectations in Buddhism to care for family members, and the significance of Thai family relationships. As care activities were integrated into stroke survivors' and carers' daily routines, feeling rules (the feeling of gratitude and the sense of

responsibility) were regulating their everyday practice and underpinning the accounts of their behaviour.

The findings of this study also lead to unique insights into how stroke survivors and carers constructed their accounts with regard to staying in control of their inward feelings and outward behaviour during caring interactions. The strategies individuals used to engage in emotion work were considered as personal skills which were influenced by culture and the background of personal experiences. It seems that stroke survivors and carers recognised the process of emotion work as an essential component of caring interactions between them.

The process of achieving emotion work may lead stroke survivors and carers to have unpleasant feelings at the time. How individuals worked on their emotions appear to depend on which strategies, surface acting or deep acting they carried out. Suffering burn-out and having a hidden conflict may be the long-term effects of emotion work on them. However, they also derived benefits from undertaking emotion work in everyday living. Emotion work is likely to be a resource in sustaining interpersonal relationships. It seems to be a way of returning good things to the other as a gift, and the feeling of gratitude, a balance between giving and receiving, may be considered an exchange for emotion work. These issues will be discussed in the next chapter.

Chapter 9

The Nature of Emotion Work

9.1 Introduction

This chapter presents a discussion of the findings of this study and the theoretical development of the performance of emotion work. The study explores the nature of emotion work during caring interactions between stroke survivors and carers in rural Thailand. It is a study of the social production of emotion work in which stroke survivors and carers regulated, expressed and explained the reasons for their feelings in the context of their reality. The study found that Buddhist morality was embedded in the participants' social context as the emotion work actually occurred. The focus of attention is how stroke survivors and carers engaged in emotion work and sustained their feelings for carrying out their everyday tasks in the context of their social reality.

I have divided this chapter into three sections. In the first, the findings of this study are briefly discussed. The second section brings all the findings together within a conceptual framework for the performance of stroke survivors' and carers' emotion work. Finally, the performance of emotion work: giving, receiving and returning, is discussed in detail.

9.2 Overview of findings

An overview of the main findings is given here in order to provide insight to the way stroke survivors and carers worked on their feelings regarding their personal beliefs, feeling rules and life experiences as resources of common-sense knowledge. Chapters 5-8 reveal the trajectory of the stroke experience and the underlying resources of social circumstances, culture, norms and personal beliefs described in terms of how stroke survivors and carers dealt with complex and uncertain situations

in connection with the suppression and expression of their feelings during caring interactions.

Chapter 5 presents the description of twelve pairs of stroke survivors and their carers' family backgrounds, pre-stroke lives and difficult post-stroke lives which affected their everyday routine living, and current life situations. The stroke event constituted meaningful experiences for stroke survivors and carers as an important aspect of their social reality. The stroke produced difficulties and turned into a major struggle in participants' everyday lives. Stroke survivors and carers in the daily life of dealing with life difficulties following stroke are revealed. The changes in family, work and social lives were reported by the participants. Data demonstrate that those life changes influenced their feelings and emotions in everyday living. The limitations of stroke survivors' physical movements were seen as an important problem alongside continued living as usual in both stroke survivors' and carers' lives. These represent their stock of knowledge which informs the rationale for the properties of various behaviours in everyday conduct.

Furthermore, participants' perspectives on taking medicines and treatments to cure stroke are included in this chapter. This section introduces the role of traditional Thai remedies (TTR) in the process of stroke recovery. Most participants believed that TTR contributed to cure physical limitations and other symptoms, i.e. communication problems and difficulties with mental processes resulting from stroke. Stroke survivors reported the experiences of using TTR, e.g. herbal medicines, acupuncture, massages, religious performances and supernatural healing rites, whereas carers agreed with the survivors using TTR. For them, TTR were used in the hope of curing stroke survivors' physical limitations and related symptoms after hospitalisation. The use of TTR was part of their personal beliefs and social norms.

Chapter 6 illustrates stroke survivors' beliefs about the cause of stroke and its effects on their attitudes towards themselves and carers. This chapter is divided into four key subthemes. The first subtheme is stroke survivors' difficult experiences and changed

lives during the first six months post stroke. Those experiences were indicated as the turning point of their lives. Findings demonstrate stroke survivors' world of experiences in dealing with the stroke event, how their lives were changed, and how they began to return to a new normality. The second subtheme is how they gave reasons for their strokes. This is about stroke survivors' accounts of how they made sense to understand why stroke happened to them. They searched their experiences to find a match with a given situation. Rationality was used for recreating their current status within social reality. The beliefs in karma and other personal beliefs had a strong influence in this subtheme.

The third subtheme involves an evaluation of their own health following stroke which provided a positive or negative attitude towards themselves and how much they needed help and support from carers. These accounts demonstrated stroke survivors as influential in managing their feelings and emotions in everyday living. The fourth subtheme is stroke survivors' attitudes towards carers. They showed their appreciation of all carers' help following stroke. They also used knowledge which was assembled from personal experience with carers' support to address the definition of a good carer although some of them had an unpleasant relationship. This subtheme provided stroke survivors' accounts and reports detailing the feeling of gratitude to carers.

Chapter 7 demonstrates carers' accounting for their care of stroke survivors, which consists of three subthemes. The first subtheme is how individuals became a main carer. The responsibility, the morality of Buddhist values and the sense of gratitude were significantly presented throughout the interviews. These accounts show how carers ensured good results and reflected social rules and norms for undertaking the caring role for stroke survivors. Data suggest that the meaning of rules and norms is continually constructed and reconstructed by carers throughout their thinking process relating to the issue of why they took the caring role.

The second subtheme is carers' attitudes towards stroke survivors' health. Carers evaluated stroke survivors as disabled or as having achieved a new normal physical

ability, based on their expectations around survivors' ability to manage routine activities. The accounts demonstrated how carers' expectations affected how they provided care for and had feelings about stroke survivors during carrying out care tasks in everyday activities. The third subtheme is the influence of neighbours divided into two categories, neighbouring as a source of encouragement, and neighbouring as a source of social pressure on carers. This subtheme reveals that neighbours reinforced carers' ideas of moral standards of caring for stroke survivors in this community. The role of neighbours appears to represent the expectation of the societal norms as an external factor in emotion work which may guide how carers are supposed to feel and act in a given situation of social reality.

Chapter 8 discusses caring interactions and explores the micro-sociological process of how stroke survivor and carer pairs engaged in emotion work based primarily on observational data. The specific feeling rules based on interview data and field notes were involved in the discussion of the process of each pair's emotion work. Data demonstrate that stroke survivors' and carers' emotion work is produced during face-to-face interactions and when they feel a misfit of feelings in a specific social context. Their attempts are to manage their inner feeling to fit a particular situation and to express it in an appropriate way. They may use surface or deep acting as their own strategy for achieving emotion work depending on social contexts, their emotional experiences, and experiences in using those strategies.

The theme of 'Emotion management' is divided into three subthemes which encourage the understanding of stroke survivors' and carers' emotion work. The first subtheme is emotion work as part of daily life. Emotion work is involved in stroke survivors' and carers' lives and it helps to keep their current life situations in balance and to continue living as usual. The second subtheme is emotion work as reflection. The achievement of undertaking emotion work is governed by stroke survivors' and carers' life experiences and their specific feeling rules. The process of reflection is utilised for achieving emotion work during care tasks. Third is about gender differences. This subtheme focuses on the different role in the family between two genders in relation to emotion work. In Thai rural families, the caring role belongs to

women. They appear to accept and be willing to do care work as part of their duty in the family. Moreover, the finding illustrated that there is no difference between the strategies of men and women in managing emotion work during caring interactions.

In summary, this study based on an ethnomethodological approach seeks to explore the nature of emotion work occurring in caring interactions between stroke survivors and their carers in rural areas of Thailand. As sociological analysis shows, the influence of culture and social contexts in everyday situations guide social members' behaviour, interactions, and feelings (Stets and Turner 2008). From this perspective, three related questions arise in order to support the main question: What is the nature of emotion work during caring interactions between adult stroke survivors and carers? First, how is the context of care between stroke survivors and carers constructed involving socially specific emotions in Thai culture? Second, how do they create their roles which they come to accept as normal practices? Third, what methods do they use to cope with emotional challenges in everyday living?

To answer the first question, I explored participants' family background, their experiences in dealing with the issues of stroke, and feeling rules. I found that stroke survivors and carers construct their context of care by making sense of the current situation they face guided by culture, social norms and structures individual life experience, and personal beliefs. The context of care emerges as a result of individuals' ideas associated with the subjective sense of care (Clark 1990). This context is created for the continuation of their daily routine activities as usual. Data suggest that emotional stances can sustain varying stroke survivor-carer relationships in the diverse contexts of care (see section 8.2, p. 188-217). A context of care associated with inappropriate expression of emotions can inhibit carers' ability to provide culturally appropriate care for stroke survivors. For example, Samart (husband-stroke survivor, pair 4) felt bored with doing hand exercises and lay in bed all day long and hardly did anything. Mena (wife-carer) was eager to persuade him to exercise. Samart refused to do so, by staying silent, expressing anger, and shouting angrily sometimes. This situation was experienced by them as painful. The demands of motivating him to exercise rendered an unpleasant feeling for Mena. She finally

gave up trying to help him exercise his hand. This may influence Samart's negative attitude towards himself and impede recovery.

For the second question, the accounts of creating stroke survivors' and carers' new roles were drawn from their attitudes and thoughts about life situations, self-expectations of stroke recovery, family economy, and the influence of social expectation. Based on their stocks of knowledge, individual experience in the trajectory of stroke, and social norms and cultures, they learn and relearn to understand how to adapt their roles to fit the current life situation. Prasit (husband-stroke survivor, pair 3), for example, practised to use routinely one hand and one leg to drive his tractor. In addition, the changing role of stroke survivors' and carers' need to hold multiple roles are found to be a source of mood alteration and emotional behavioural changes among them which may lead to the act of undertaking emotion work. For example, Pichai (husband-stroke survivor, pair 2) accepted that his moods changed from hot-headed to calmer after having a stroke due to feelings of guilt about former abuse of his wife and gratitude for all her help. Wipa (wife-carer, pair 9) realised that she had to hold multiple roles after the stroke event. Taking care of her husband, and earning money for family expenses were added to her basic role as a housewife who did household chores and looked after her granddaughter. These roles and management of her domestic and working schedules resulted in stress during everyday interactions between her and her husband.

The third question is about what methods stroke survivors and carers use to cope with emotional challenges in everyday living. When individuals encounter emotional difficulty, a variety of techniques for emotion management are utilised (Clark 1990). Data demonstrate that both stroke survivors and carers reported varied techniques for managing their emotions while facing an emotional misfit such as reinterpreting the situation, stopping thoughts, accepting the situation, seeking support, meditation, chanting, withdrawal, hiding feelings and relaxation. These techniques may or may not help them to cope with emotional problems in their lives. However, the techniques lead to specifics on how they perform and accomplish emotion work.

The overall findings illustrate that stroke survivors and carers engage in emotion work when interacting with each other in the home environment which fits with the concept of emotion work developed by Hochschild (1979, 1983). This concept allowed improvement in in-depth understanding of the nature of stroke survivors' and carers' emotion work in terms of the meaning in Thai culture. All participants were able to create acts of trying to manage their own feelings and make changes in degree of those feelings by regulating and suppressing the intensity of a feeling including expressing a desired or expected emotional display in a given situation (surface or deep acting). The cognitive, bodily and expressive techniques of emotion work were found as part of their everyday activities. Emotion work was performed when they were pressured from their perception of demands to conform to emotional norms as their feeling rules. Feeling rules are a set of social guidelines which were mainly associated with the feeling of gratitude and the sense of responsibility based on their belief in Buddhist values. Furthermore, participants' attitudes and life experiences in emotional strategies for managing a feeling play an important part in their stock of knowledge and skills embodied in their ability to engage in emotion work. The needs for establishing peace and smoothly running family lives and for maintaining interpersonal relationships emerge through their intention to engage in emotion work in day-to-day routines.

The next section presents the conceptual framework of how stroke survivors and carers engage in emotion work in daily living. The discovery of the way they both use and exchange values in the process of emotion work are revealed.

9.3 Conceptual framework

It is necessary to confirm that 'emotion' and 'feeling' are used interchangeably as terms in this study (Hochschild 1979). Emotions are introduced as strong feelings occurring in the home environment based on individuals' subjective experiences, their thoughts and memories in connection with awareness of social regulation in the context of social cultures, norms, and reality, and are focused on the way individuals work on their emotions internally and express appropriate emotions publicly.

The conceptual framework which explains the process of emotion work among stroke survivors and carers presented here has been gleaned from all the findings of this study, consisting of four components (context, generation, expression of emotion and feedback). This conceptual framework has been developed from the empirical reality of the findings of everyday situations during caring interactions in the home environment, and describes the nature of emotion work that occurs. The framework provides a particular idea of, and relationships to, related factors that have been found important to answering my research questions. In the context of the micro-practice of everyday caring interactions, the framework makes stroke survivors' and carers' emotion work visible. A central concern in an ethnomethodological perspective (Garfinkle 1967) is to understand participants' sense-making of a particular situation while engaging in emotion work. The framework stems from the findings of Chapters 5, 6, 7 and 8. Chapter and section numbers are inserted into the framework in order to make explicit where those issues were presented in the thesis.

The process of emotion work can be demonstrated by the relationship between all components leading to the discovery of a theoretical representation and explanation of the performance of emotion work (giving, receiving and returning). This will be discussed later in this chapter. The conceptual framework of emotion work is theorised through the relationship among the four components: context, generation, expression of emotion and feedback. I use arrows to show the relationship between each component of the framework in Figure 9.1.

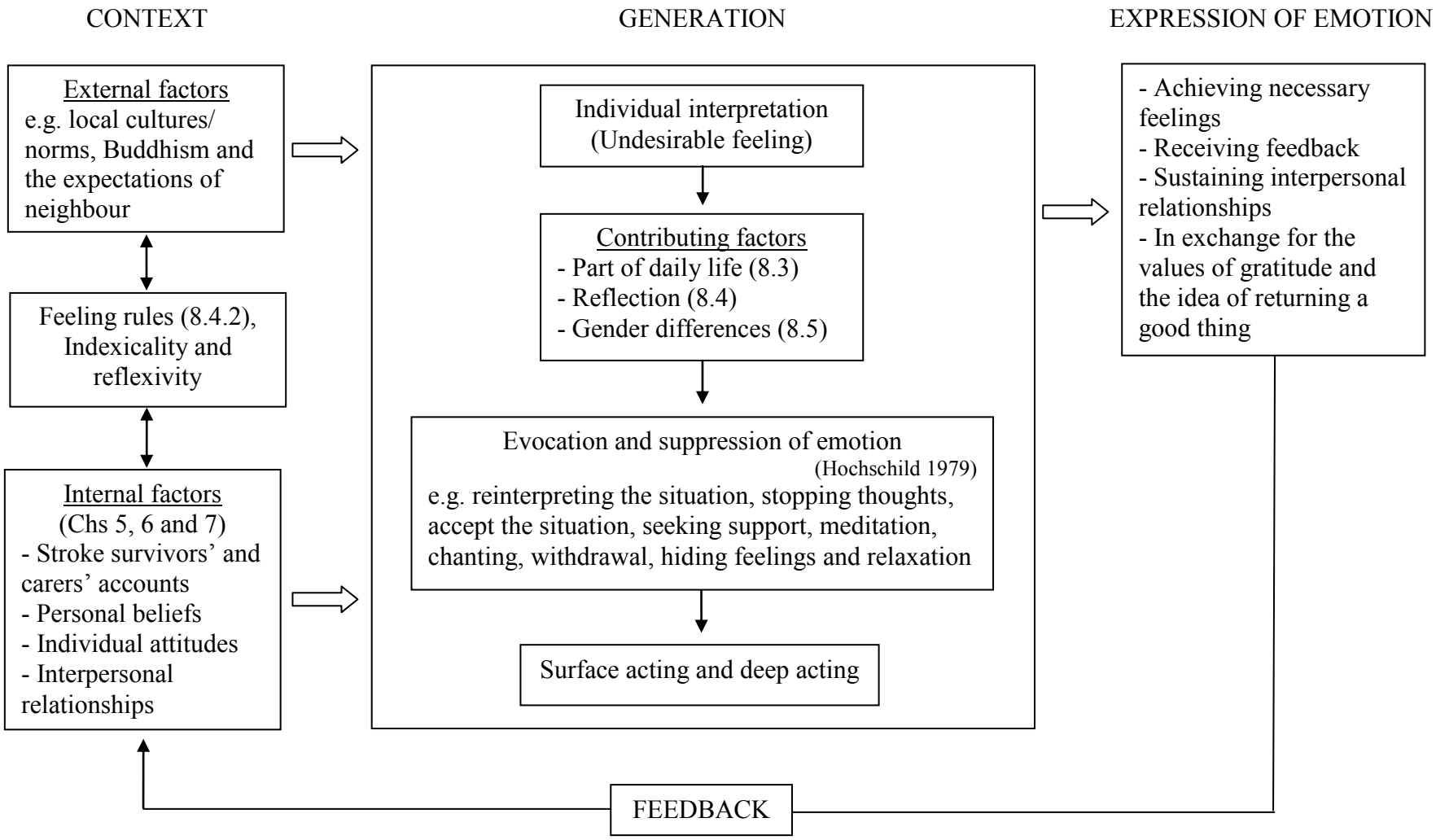


Figure 9.1 The conceptual framework for the performance of emotion work among Thai stroke survivors and carers

I am now going to explore each of the components in greater depth, starting with context.

Context. Context represents inducing events for emotion work. It is divided into two factors. Firstly, external factors are the circumstance of local cultures/norms, Buddhist doctrines and the expectations of neighbours, all of which are influential in shaping the occurrence of the inducing events. Secondly, stroke survivors' and carers' personal beliefs, attitudes and interpersonal relationships are involved in internal factors. Stroke survivor-carer interactions in everyday living produce a sequence of routine care events and emotional experiences in the home environment. An appraisal of events relates to the sense-making systems of cognition and emotion to environmental stimuli (Hoekstra and Stoop 1989: 230). Stets and Turner suggest the concept of cognitive appraisals that is conceptualisation of the self, others and situations, and a state of emotional arousal that is "generally conceived to flow along a positive-negative polarity, with specific emotions emerging as a result of the responses to self and others, a cognitive assessment of one's place in social structure, and knowledge of the relevant cultural guidelines" (Stets and Turner 2008: 33). In this sense, an emotional state in a particular situation can be interpreted by the system of personal cognitive appraisals and emotional arousal concerning culture and social structure (see section 2.4, p. 39-46). With regard to Chapters 5, 6 and 7, the findings reveal stroke survivors' and carers' accounts in connection with emotional issues in day-to-day life following stroke. The accounts demonstrate the underlying sources of awareness of their roles and personal beliefs which have an influence on their feelings and behaviours in everyday living. This provides insight into how they understand emotion-producing events and how they realise and make sense in a given situation in which they must perform emotion work.

In this study, an inducing event is the understanding that stroke survivors and carers give to a particular situation to guide their feelings to undertake emotion work. The understanding of an event develops from the process of how stroke survivors and carers interpret a particular situation concerning the relation between personal interpretation of situations in sum (cognitive appraisals and emotional arousal) and environmental influences. This perspective is similar to the rules that Hochschild

(1979) calls ‘framing rules’. Individuals are guided by framing rules to understand and conclude the definition of a given situation where social norms are also applied to their perceptions (Stets and Turner 2008). Stroke survivor and carer approval of their framing rules may hinge on their images, thoughts, and emotional experiences related to the appropriateness of making a decision on undertaking emotion work (Rietti 2009).

External and internal factors in context appear to be influenced by personal feeling rules, indexicality and reflexivity. It is clear that feeling rules guide what individuals should feel in a given situation (Hochschild 1983). The findings of this study suggest that feeling rules can help stroke survivors and carers specify what emotions should be felt and displayed in order to minimise trouble during caring interactions. It can be said that internal factors are informed by personal feeling rules, and external factors can be recognised through part of the stroke survivors’ and the carers’ own feeling rules. The notion of feeling rules will be discussed further in the section on ‘generation’.

Indexicality of meaning and reflexivity of account are part of both the methodological and theoretical framework. An ethnomethodological approach provides a way to look beyond the activities of interactions to common practices accomplished by social members through the creation of a meaning for a particular context (indexicality) and social members’ accounts on its context (reflexivity) as based on Garfinkel’s perspective (1967). The nature of activities in everyday situations is defined by the contextual meaning, and the interpretation of a given situation which affects how social members make common-sense decisions (David 2009; Goodman and Strange 1997; Marcon and Gopa 2008; Phillips 1992). Through an ethnomethodological lens, indexicality and reflexivity affect stroke survivors’ and carers’ understanding of the particular context. Therefore, feeling rules, indexicality and reflexivity can activate external and internal factors of stroke survivors and carers to engage in emotion work in a given situation. At the same time, current information on the specific emotional experience in connection with those factors becomes their stock of knowledge as the two-way arrow indicating the directions of relationships suggests.

Context in this study refers to culturally-situated consciousness such that particular situations elicit specific emotions in stroke survivors and carers. These events include dealing with uncertainty in life, chaos in household and care tasks, unpleasant emotions, individuals' expectations, and the presence of external forces in a frustrating situation as shown in Chapter 8. In everyday routine activities, such trigger points may produce, for example, the feeling of shame, fear and guilt about their behaviour towards one another which then influences them to decide to engage in emotion work. Emotion work can be demanded by stroke survivors and carers of themselves through their self-monitoring of the need for doing emotion work in everyday lives.

In summary, the context arm of the conceptual framework, an inducing event includes external and internal factors influenced by feeling rules, indexicality and reflexivity. This component illustrates the practical reasoning behind stroke survivors' and carers' decision to engage in emotion work during caring interactions in their everyday living. The context arm appears to be accountable for the sense-making process that individuals utilise for constructing meanings for themselves to reach the feelings necessary for undertaking emotion work in a given situation.

Regarding external and internal factors, the description of stroke survivors' and carers' life experiences, common-sense knowledge and their accounts regarding the construction of the context of care and the creation of their role following stroke reflect their beliefs in Buddhist doctrines, especially, the law of karma and the system of gratitude in Thai culture. These factors are shaped by feeling rules which are social conventions connected to the accepted feelings and emotions which give practical guidance on what individuals should feel in a particular situation. The two factors are also under the influence of the concepts of indexicality and reflexivity in ethnomethodology which are resources of knowledge available for individuals to make sense of everyday situations at hand. The ethnomethodological perspective allows for viewing this component (i.e. 'Context') as an actual ongoing activity and/or a never-ending process.

Generation. Generation concerns how stroke survivors and carers seek to achieve emotion work so as to carry out their roles in day-to-day routine living as usual. According to the perspective of emotion work (Hochschild 1979), feelings are regulated by evocation and suppression (see also section 2.3, p. 25-39). Those feelings are actively generated, i.e. shaped and directed, in reference to individuals' recognition of social norms (Wharton 2009). The process of undertaking emotion work is associated with two dimensions, emotion work techniques and stroke survivors' and carers' own feeling rules, which are indicated by self-monitoring and self-evaluating.

As suggested in Chapter 8, the nature of emotion work is explained from three points of view. First, stroke survivors and carers tend to consciously engage in emotion work during caring interactions when they find themselves experiencing an emotional misfit in a given situation as part of routine activities in their everyday living. Second, reflection of stroke survivors and carers in relation to their life experiences and feeling rules plays into the basic processes of creating a particular emotional state and of defining the nature of their emotion work. Third, difference in traditional gender roles for particular kinds of tasks within the family and a change in these roles following stroke contribute to various forms of emotion work (surface or deep acting). The traditional gender roles led more women than men to become more involved in the caring role. Although both women and men could achieve emotion work, the accounts of performing emotion work and underlying beliefs were different. For women, the involvement of female role expectations in forms and amounts of emotion work emerged as an important link to the feeling of gratitude. For men, performing emotion work involved an expectation of undertaking caring roles as regards the sense of responsibility. It is clear that the three points of view, i.e. emotion work as part of daily living, emotion work as reflection, and gender differences, emerge as the contributing factors involved in the accomplishment of emotion work.

Undesirable feelings, e.g. shame, anger, anxiety, guilt and stress, encourage the demand for emotion work occurring even in pairs with a bad relationship (see

Chapter 8, pairs 7 and 9). However, participants who experience an unpleasant relationship appear to process outward emotional expression through using only surface acting. It implies that the demand for emotion work is not related to the quality of interpersonal relationship. Therefore, all participants can experience the need for emotion work and be able to achieve emotion work in a particular situation. The awareness of performing emotion work among stroke survivors and carers may be guided only by their own feeling rules and normative expectations about how they ought to feel and behave in order to bring them in line with appropriate feelings.

Stroke survivors and carers use a variety of emotion work techniques observed throughout the activities of surface and deep acting to control outward feelings in front of one another. Hochschild (1979: 562) states that three techniques of emotion work are cognitive, bodily and expressive emotion work (see section 2.3 p. 25-39). Keys's (2005) study of women undergoing experience of abortion introduces approach/avoidance technique besides Hochschild's original list of emotion work techniques. It is evident in Keys's study that the original techniques were used for controlling participants' feelings when facing environmental stimuli in connection with the abortion and that women used the approach/avoidance technique to either seek out or avoid exposure to threatening environments. It appears that emotion work techniques can be generated in order to anticipate making an effort to control an emotional state in a particular situation.

According to the findings of my study, bodily techniques, i.e. taking deep breaths, shaking head, changing gestures slowly, keeping calm, and stopping laughing and smiling; and expressive techniques, i.e. changing facial expression and smiling are utilised to manage stroke survivors' and carers' feelings. Cognitive techniques may also be used because there is evidence of mental effort to attempt to distance themselves from the sources of unpleasant or undesirable feelings. These efforts are based on Buddhist beliefs and practices applied to the ways of their everyday living. Some participants used the avoidance technique to prevent them having the feeling of anger and nervousness. These techniques are divided into surface and deep acting with reference to observational and interview data including field notes due to my

intention of comparing my findings with regard to emotion management, with the concept of emotion work. The occurrence of surface and deep acting can be found together in the same scene. Stroke survivors' and carers' emotion work is performed as communication with each other to convey information and to express their feelings and emotions in everyday affairs (Rietti 2009).

Mann (2005: 311) claims that the production of emotional labour can be accomplished through both acting in bad faith (individuals have to perform emotional labour as a result of having emotional conflict with display rules of an organisation) and acting in good faith (individuals follow feeling rules and want to perform emotional labour). This means that an emotional misfit can be induced by both feeling rules and display rules. However, this perspective may be suitable to apply to emotional labour in healthcare contexts and organisations because the organisation's rules and regulations guide how healthcare professionals ought to feel and behave. For my study, stroke survivors and carers appear to perform emotion work through acting in good faith. It appears that they feel bad when they do not feel as they think they should feel. They want to perform emotion work according to their thinking on the right thing to do in a particular situation. The degree to which they worked on inner feelings is promoted for two reasons. Firstly, cultural beliefs and social norms appear to promote the requirements for emotion work (Peterson 2007, Stets and Turner 2008). Secondly, the performance of emotion work is relevant to individuals' moral virtues (Stets and Carter 2012).

As suggested in the discussion of context, emotion work is under the influence of feeling rules (Hochschild 1979, 1983). With regard to stroke survivors' and carers' feeling rules, the feeling of gratitude and the sense of responsibility represent a social expectation about appropriate feelings in a given situation (see section 8.4.2). Their feeling rules are connected with moral feelings and moral actions in social reality in order not to destroy an interpersonal relationship between them. This moral foundation is motivated by the ethical basis of individuals' beliefs in Buddhist values, and as such underpins a form of ethical caring. In the private realm of the family, stroke survivors and carers appear to perform emotion work because they want to do

it. This feeling was guided more by feeling rules than by neighbour prescribed display rules. However those neighbours seem to be positioned as a reminder to survivors and carers of feeling rules.

The association between feeling rules and the performance of emotion work is denoted above as a form of ethical caring occurring between stroke survivors and carers. However, this study uses the term in a different way from Noddings (2003: 81-83), who introduces the term 'ethical caring'. She means the act of caring as a result of the appropriate response associated with "I must". Ethical care is supported by natural caring, which she associates with the feeling of "I want". Natural caring represents an innate characteristic which occurs in ordinary practice without the requirement of ethical effort to stimulate it. According to Noddings, the individual should use natural caring rather than ethical care to develop the duty to care (Hassan 2008; Smith 2004). If I use the term 'ethical caring' in the same way as Noddings, it would suggest the performance of emotion work is influenced by the sense of responsibility rather than including the feeling of gratitude as the basis of thoughts and feelings in a certain situation. I primarily use 'ethical caring' to describe moral actions influenced by moral reasoning and moral feelings regarding how stroke survivors and carers actually feel and try to feel in the belief that those feelings are appropriate for the other in a given situation according to their own feeling rules. Stroke survivors and carers tend to achieve emotion work because they want to do it instead of feeling that they must do it. This is in order to repay for their mistakes in their previous lives according to Buddhist beliefs and to pay a debt of gratitude to each other.

Expression of Emotion. The expression of emotion is the achievement of stroke survivors' and carers' intention to perform emotion work. This means that they can express an appropriate emotion and fulfil the requirements of their demanding situations. Although Hochschild (1979) stated that one may or may not accomplish emotion work despite following feeling rules, I found that all stroke survivors and carers appear to achieve emotion work during caring interactions while showing a

willingness to undertake it with regard to the feeling of gratitude and the sense of responsibility in line with their feeling rules.

There are two meanings of accomplishment for stroke survivors and carers in performing emotion work. Firstly, they may be able to achieve necessary feelings. Their inner feelings are compatible with what they want to feel in an existing situation. Secondly, they receive feedback from one another which may or may not live up to expectations. As based on my data set, emotion work foregrounds its role in maintaining interpersonal relationships and in avoiding a situation bringing them into conflict. The essence of achieving emotion work among stroke survivors and carers develops from the internal actions of mind as a way of giving, receiving the feeling of gratitude and returning a good thing to each other as compensations. These are discussed in the next section.

Feedback. Goldie stated that "perceptual experiences can themselves provide reasons for empirical belief and judgement" (Goldie 2004: 251). The experience of the emotion work process is stored as the stock of stroke survivors' and carers' knowledge through their perceptions. Their knowledge of accomplishing emotion work in relation to personal beliefs is made available and utilised in interaction with each other in order to live as an ordinary member in society. Therefore, feedback is considered as reference knowledge used to alter the gap between their actual feelings and expected feelings in order to provide a possible situation for undertaking emotion work in the present or future. Any prior knowledge of emotion work can provide good reasons for deciding whether or not to engage in emotion work in a certain situation as framed by individual feeling rules or socially defined rules (Hochschild 1979, 1983; Wharton 2009).

To summarise, the process of achieving emotion work consists of four components. Firstly, context illustrates how emotion work is activated in a particular situation regarding a social interaction. The individuals respond to an inducing event for emotion work affected by, for example, external factors such as cultural social norms, Buddhism, and the expectations of neighbours, which stimulate their feeling. Internal

factors in context are influenced by their stock of knowledge and personal beliefs. Individuals' feeling rules and their indexicality and reflexivity influence how they must feel and behave in a particular situation. Secondly, generation reveals how individuals regulate their feelings through emotion management techniques. The individuals have benefit from using their sources of information and may interpret the specific feeling as an undesirable feeling. Contributing factors have an effect on whether surface acting or deep acting is utilised. Thirdly, expression of emotion shows the production of emotion work according to the purposes of performing emotion work. Finally, feedback is an expression of feelings stored for future use.

Stroke survivors and carers include themselves in their environment and count themselves as a social member who obeys the rules of social norms. The existence of their emotion work is treated as a cultural event that is an obligation of membership. Its existence is also consulted through self-reflection as individuals seek the way to regulate their own feelings to fit the expectations of social norms. The recognition of feeling rules is made normal for social members to generate appropriate feelings and actions in a society. Stroke survivors and carers are able to accomplish emotion work in the cultural environment of a normal member of the society through the common sense of its being morally right and correct. They appear to insist on their own responsibility and to exchange gratitude to deal with undesirable feelings in everyday routine lives.

9.4 The performance of emotion work: giving, receiving and returning

There are various occasions on which stroke survivors and carers undertake emotion work. When they undertake emotion work, these occasions appear to be a way of showing gratitude. The occasions of undertaking emotion work produce three activities regarding the values of gratitude in exchanging emotion work with the other. The first two activities are the acts of giving and receiving. In this study, giving and receiving are the acts of bestowing the values of gratitude. The third activity is returning which is about sending the values back to the other, to whom individuals are obligated because of doing a 'bad' thing in their previous lives. The values

represent a good thing that individuals perform in the present. Although they cannot specify what, when and where they did the bad thing, they just accept and return good things back. It is the law of karma (cause and effect) based on beliefs in Buddhist doctrines.

The performance of emotion work is a way of achieving the demonstration of gratitude to the other and the return of a good thing (Bun). Stroke survivors and carers show a willingness to undertake emotion work during caring interactions and appear to be able to handle it without reluctance. They each also convey the message to the other that they ought to feel an expected way in a certain situation. The elements of the performance of emotion work are affected by their beliefs and accounts.

The performance of emotion work is not only a matter of stroke survivors' and carers' desire, but also a necessary activity in everyday living. Although stroke survivors and carers want to perform emotion work, they may or may not like it. However, they have to go past this situation as part of their routine activities. For example, some participants talked about the feeling of stress and having unpleasant feelings while carrying out the task of emotion work and achieving it. This implies that they decide to engage in emotion work despite it causing predicted stress and undesirable feelings. The intention to show gratitude and returning a good thing is sufficiently important to undertake emotion work instead of ignoring it. In this sense, the stress and unpleasant feelings appear to occur normally in exchange between the values of gratitude and of a good deed and the process of achieving emotion work.

With regard to the acts of giving and receiving based on the account of indebtedness, gratitude is associated with acknowledging how the individual receives something beneficial or kind from someone (O'Connor 2012; Wijesinghe 2008). A situation in which stroke survivors and carers reciprocate support is found in the process of emotion work during caring interactions in the home environment where the caring process in the family is various and dynamic (Richardson et al. 2007). In the work of Hochschild (1989) by conducting interviews with fifty couples and observing twelve

homes in U.S. society over a period of eight years, a key to a successful and lasting relationship between partners depends not only on the equal division of household chores, but also the expression of gratitude that they each give to the other. Hochschild's phrase 'economy of gratitude' refers to what individuals give and receive as a gift between them. The valuing of a gift is recognised as the extra benefit from the other's efforts. This means that individuals identify a gift to them when something or tasks are not taken for granted as yours. Then they each are likely to feel gratitude toward the other for what he/she does.

The findings of my study suggest that stroke survivors and carers not only provide practical and emotional support, but also receive support from one another. For practical support, carers provide physical care and support for stroke survivors in the context of considered necessity for a person with physical limitations (Bulley et al. 2010; Cecil et al. 2010); and they are also receivers of practical support from most stroke survivors in carrying out household chores such as cleaning, cooking and gardening. A reversal of traditional domestic roles in the family can be found. With reference to Hochschild's economy of gratitude, stroke survivors and carers do feel gratitude toward each other for giving practical support because they view practical support as the other's efforts for them. It can be said that they perform the exchange of gratitude, and the practical support represents a gift which encourages an expression of their gratitude for each other.

For emotional support, carers were viewed as a key person for providing emotional support to stroke survivors (Jullamate et al. 2006; O'Connell et al. 2001; Rosenberg et al. 2009). However, I found that emotional support is provided by both carers and stroke survivors. Performing emotion work appears to be one of the provisions of emotional support. All couples without exception try to undertake emotion work in order to show gratitude for the work the other one does. The reciprocity of practical support and performing emotion work can be seen as a way of displaying the normality between them in the family home and to maintain the values of gratitude. Thus, the reciprocal nature of support appears to minimise the impact of emotional conflicts between them in normal everyday affairs.

I examined ‘economy of gratitude’ in Hochschild’s sense, which is an exchange to manage daily life and relationship between couples or among family members, and found that this idea does not fit the nature of gratitude in the Thai context perfectly. Data suggest that stroke survivors and carers appear to have the feeling of gratitude for all of each other’s support. They each then tried to perform a reciprocal action of kindness to the other. However, the nature of gratitude between them cannot be explained by looking solely at the interplay between their gratitude as the exchange of a gift to each other. As described in section 2.4, gratitude appears to be embedded in Thai people’s minds; the real sense of gratitude is associated with strong cultural and Buddhist obligations. Therefore, the nature of stroke survivors’ and carers’ gratitude is from not only the sense of mutuality, the reciprocal kindness, but also the sense of a powerful duty of gratitude. The requirement of gratitude between them seems to be given rather than exchanged based on karma and Buddhist teachings.

Hochschild illustrates family myths which are “versions of reality that obscure a core truth in order to manage a family tension” (Hochschild 1989: 19). She found that each couple uses family myths and strategies to create a peace and to make decisions about the problem of household inequality in the family home. Each couple has its own family myths and strategies to manage the tension between them. In this study, stroke survivors and carers perform emotion work to show that everything is fine to enable daily life. It implies that the idea of engaging in emotion work is a strategy to sustain the myths in order to avoid conflict between them. During caring interactions, they may have to believe the true feeling myth and to accept the expression of those feelings as a result of achieving emotion work.

In addition, the concept of caring for and caring about is useful when exploring emotion work undertaken by stroke survivors and carers. According to Noddings (2003), caring-for refers to how a person provides face-to-face care to the other, occurring in the form of caring activities, while caring-about refers to the state of feeling concerned about others (see also Smith 2004). Caring-about can reinforce a sense of caring-for (Noddings 2002). In my study, it is clear that stroke survivors were cared for by carers, but the context of providers and receivers appears to be

dynamic in the sense of engaging in emotion work in which they each have priority in turn. As discussed earlier, emotion work is accomplished by reflection regarding feeling rules as the process of emotion work is running through individuals' minds. Therefore, caring-about becomes a central part in the moral reasoning of self-reflection on performing emotion work instead of caring-for. However, the act of undertaking emotion work appears to be a task of caring-for the other which is enhanced by individual's moral reasoning through the concept of caring-about. Stroke survivors and carers appear to be appreciative of each other's help and support. They each recognised and acknowledged a benefit received from the other. This account influences them to perform emotion work. They also expressed their desire to achieve emotion work in order to make the other recognise this occasion and act in a similar way. This study suggests that the act of giving and receiving gratitude is important to motivate individuals to perform emotion work based on moral decision-making as expressing the state of being obliged to each other.

With regard to the idea of returning a good thing, the performance of emotion work is grounded in the longing to repay compensation to the other. Since the stroke event and related situations following stroke were accepted by stroke survivors and carers as their own fate caused by a bad thing in their past lives, they were willing to pay for their mistakes with a good thing, following the law of karma. Payutto (1993) stated that the definition of karma in the Thai Buddha's teaching is human actions and the state of intention. In the context of Thai Buddhism, intention includes all actions, speech and thoughts regarding one's own volition of mental concerns. Karma is an action led by intention (Egge 2002). The process of cause and effect relates to a result of previous karma or past action, a determinism which has an influence on the present life as a conditioning factor. However, the individual can react to the situation and decide what to do in the present moment oneself (Payutto 1993). It implies that previous karma or past actions has an undeniable effect on an individual's present life. This account can help the individual understand the present situation at hand and learn from it. He/she can also improve the present action through self-awareness and do good karma for the future.

I found that stroke survivors and carers assumed the work of achieving emotion work as a good thing (Bun) which they would do for altering the values of the personal debt of bad karma done in their past lives based on the beliefs in the Buddhist doctrine of karma (see section 2.3.3, feeling rules, p. 30-34). The result of previous karma cannot be removed from the law of cause and effect, but it can be presently replaced with good karma. For stroke survivors and carers, it is not a matter of being true or not to this idea, but at least the idea helps them to understand the present situation according to reason in terms of cause and effect, and they can continue living as usual and keep the peace within the family life. It can be said that emotion work is one of their accessed chances of returning a good thing in compensation for their own former mistakes and of repaying the debt of bad karma. It also is a way of doing good karma.

In summary, the performance of emotion work among stroke survivors and carers is defined as the acts of giving and receiving gratitude to each other and returning a good thing in compensation. Emotion work is done via active regulation of their inner feelings involving background knowledge and how they interpret a particular situation, and it is a result of rational actions which are practically conducted in everyday affairs. The process of achieving emotion work is viewed as everyday common sense when the rationality of regulating inward feelings and expressing outward feelings and actions is congruent with personal beliefs and their own accounts in accordance with the particular situation. It can be said that stroke survivors and carers perform emotion work through their own practical reasoning in order to fulfil the feeling of gratitude towards the other and to accomplish a desire to satisfy its religious obligation to serve their own beliefs regarding cultural and social norms.

9.5 Summary

This chapter illustrates the nature of emotion work regarding the entire findings of this study and draws attention to the way stroke survivors and carers co-construct the performance of emotion work in the home environment. The sense of responsibility

and the feelings of gratitude based on the beliefs in Buddhism play a role in their own feeling rules which shape stroke survivors' and carers' minds to perform emotion work. The process of achieving emotion work is divided into four components. Firstly, context is the predisposition to receive a particular stimulus to engage in emotion work which consists of external factors, norms/cultures in society; and internal factors regarding personal beliefs, attitudes, life experiences and the quality of their interpersonal relationship. These are framed by individuals' feeling rules, indexicality of meaning and reflexivity of account. The second component is the generation of how the individual manages their inner feelings through surface acting or deep acting. The expression of emotion is the third component of this process which represents an appropriate feeling and behaviour expressed in a given situation in order to sustain interpersonal relationships and avoid conflict arising between them. Within this component, the performance of emotion work is highlighted as the act of what stroke survivors and carers give and receive from each other in connection with the feeling of gratitude, and the intention to return good karma to compensate for what they did in the past based on Buddhist doctrines of karma. The last component is the feedback resulting from the expression of emotion work. This component informs the stock of knowledge used for accomplishing emotion work on future occasions.

The next chapter will draw final conclusions from all entire findings, referring to the new conceptual framework for understanding the performance of emotion work.

Chapter 10
Conclusions

This chapter aims to sum up the entire study findings. The content of the chapter is outlined in five sections. The first section illustrates the unique contribution of this thesis. Second, limitations of the study are described. Following on from this, implications for policy makers, nurse educators, community nurses and related healthcare teams, and researchers are presented. Then, recommendations to support stroke survivors and carers in the community are provided. There is a final concluding section.

10.1 Contribution to knowledge

This PhD thesis seeks the answer to one main question: What is the nature of emotion work during caring interactions between adult stroke survivors and carers in the rural areas of Thailand? To explore the main question, three sub-questions were then developed with the intention of explicating the co-construction of ideas to demonstrate the work undertaken by both survivor and carer on an undesirable feeling in order to show an appropriate feeling publicly. The three sub-questions consisted of (i) how the context of care between stroke survivors and carers is constructed involving socially specific emotions in Thai culture, (ii) how the stroke survivors and carers create their roles which they come to accept as normal practices, and (iii) the methods they use to cope with emotional challenges in everyday living. The relationship between each sub-question and the main question emerged as essential ingredients of exploring the nature and performance of emotion work among Thai stroke survivors and carers.

The study adopted an ethnomethodological approach which focused on social members' common-sense knowledge and their practical reasoning in everyday life. Twelve stroke survivors and twelve carers in the rural areas of Nakhon Sawan Province, Thailand took part in this study. Qualitative interviews, observations, and

field notes led to novel insights into their everyday routine living at home. All data were collected by the researcher. Interview data were analysed manually by using thematic analysis to develop and identify themes and to explore a possible pattern to demonstrate the process of emotion work. The process of emotion work was explicit in what stroke survivors and carers believed underpinned their thinking when undertaking emotion work during caring interactions. Emotion work plays an important role in long-term care in the home environment. In this context, the intensity of both caring activities and the routine emotion work appears to increase in the struggle to define an appropriate feeling in a given situation.

There are seven significant contributions to knowledge drawn from the entire study findings. First, stroke survivors' beliefs and experiences were explored. This leads to improved understanding of what stroke survivors imagined and thought about themselves and their carers. The stroke event brought them severe life difficulties. They struggled not only to adapt their ways of living resulting from physical limitations, but also to deal with emotional suffering and social isolation which increased over time. Stroke survivors sought and established a plausible explanation for why they had had a stroke, which gave them inner peace and helped them to accept their situation in order to continue living within individuals' life conditions. Their accounts appear to be mainly influenced by cultural norms and religious beliefs. In thinking about themselves, they established a picture of their ability either as an 'ill' person or as achieving a state of equilibrium despite physical limitations following stroke. In thinking about carers, the definition of a good carer is a way for the stroke survivors to express their gratitude to their carers. These perspectives appear to affect how the stroke survivors felt and behaved in a given situation.

Second, analysing accounts from carers about undertaking the caring role for stroke survivors lead to a better understanding of how they considered being a main carer, which was shaped by a sense of duty, moral practices and reciprocating kindness. Their attitudes towards stroke survivors' health as either a disabled person or a 'normal' person with physical limitations influenced their feelings and behaviour towards stroke survivors in everyday living. The role of neighbours provided both a

source of encouragement and a source of social pressure on carers which enhanced their sense of responsibility for the stroke survivors' care. These data demonstrate the close linkage between carers' practical actions and how the context of care is constructed. It appears that the nature of a sense-making context is dictated by emotional, reasoned and practical issues leading to the adaptation and modes of carrying out care for stroke survivors.

Third, the findings support Hochschild's (1979, 1983) perspective on the nature of emotion work. The survivors and carers undertake emotion work in order to evoke the desired feeling and suppress the unpleasant feeling in order to express an appropriate feeling compatible with a particular situation and to avoid causing emotional distress to the other. Much effort to achieve emotion work was found during caring interactions between stroke survivors and carers. Emotion work was involved in their everyday routine activities carried out within the family home. Self-reflection guided by personal life experiences and their own feeling rules took a central role in the process of performing emotion work. The difference between genders provided understanding of gender roles within the family and the rationale behind each gender's decision-making to engage in emotion work. However, there were no gender differences in the actual strategies of emotion work undertaken by both men and women. Although emotion work is integral to normal routine activities, the pressure of undertaking emotion work can be seen as a cause of stress and emotional burden in particular contexts.

Fourth, a new understanding of the process of emotion work is uncovered by taking an ethnomethodological perspective. The performance of stroke survivors' and carers' emotion work highlighted an exchange of giving and receiving gratitude and returning a 'good' thing (such as doing a good deed, having a good thought and saying a good word) to the other according to their belief in Buddhist doctrines and moral practices. The findings suggest that the survivors and carers may or may not achieve the desired feeling, or receive any desired feedback from the other. However, the act of emotion work during caring interactions between them can be found in exchange for the values of gratitude and doing a 'good' thing. Therefore, engaging in

emotion work emerges as a method to show stroke survivors' and carers' gratitude to the other and represents one of several ways to fulfil their religious beliefs about karma in everyday affairs. It can be said that the nature of emotion work is based on practical reasoning behind personal conclusions from stroke survivors' and carers' common-sense knowledge of social norms and cultures. Moreover, emotion work appears to be integral to the tasks of physical activities and caring interactions involved in their everyday routines.

Fifth, stroke-related impairments hindered both stroke survivors and their carers from continuing to live as before the stroke event. Stroke survivors and carers searched for a cure for disabilities following stroke using traditional Thai remedies (TTR) and other remedies. TTR, e.g. herbal medicines, acupuncture and massages and other remedies such as injections from quacks, religious performances and supernatural healing rites, were reported as used after discharge from hospital despite no guarantee of safety and efficacy as resources for raising hope for a cure. They tended to use all possible remedies that were available to them. Western medicines were used for curing other chronic illnesses (such as hypertension and diabetes) instead of aiming to cure disabilities. The findings enhance understanding of how disabilities mattered to stroke survivors and carers and of how they chose and evaluated these particular remedies. The use of TTR and other remedies also leads to understanding of the strong relationship between personal beliefs and their everyday living. It would be beneficial to stroke survivors and carers that health professionals pay attention to the safe use of TTR and other remedies following a stroke, and that the improvement of 'Phaet-Phaen-Thai' projects (see also p. 124-125) is more effectively incorporated into the public healthcare sector in Thailand. Moreover, the improvement of access of stroke survivors and carers to the healthcare sector and the development of health providers' approach to this group of people need to be considered in order to enhance public healthcare policies and systems.

Sixth is a point which provides better understanding of stroke survivors' and carers' life difficulties following stroke. A difficulty most participants were facing was financial problems resulting in additional stress in order to continue living with their

limitations associated with being a stroke survivor or carer. This means that they need more emotion work to deal with this particular context of their lives. Financial problems may affect a speedy recovery from stroke but further in-depth research is required to explore this issue. However, financial problems should be one of the considerable concerns for community nurses and health professionals to ensure a holistic approach to stroke survivors' and carers' quality of life. The professionals are in a good position to provide the survivors and carers with useful information regarding financial help and advice available from local social support services.

Seventh, ethnomethodology provides an approach to studying social member's everyday activities. For this study, the strength of ethnomethodology was to reveal the way in which stroke survivors and carers construct, reason and formulate their actions in a particular situation. The benefit of adopting an ethnomethodological perspective is mainly to explain how stroke survivors' and carers' emotion work is enacted in everyday living, to discover the strategies used for achieving emotion work and to explore the practical reasoning behind the performance of their emotion work. Moreover, the nature of qualitative research and the rigorous methods used to conduct this study in order to ensure credibility (through triangulation and member checking); dependability so that the process can be followed again with similar outcomes through using reflexivity and detailed description of methods; confirmability through detailed discussion of data and analysis and where reflexivity is important in dealing with preconceptions, bias, etc., and transferability (thick descriptions), all give the potential to generalise about similar characteristics that are transferrable to similar situations.

10.2 Limitations

Several limitations have been found within this study. The first is about the characteristic of the study's sample. The small sample size of stroke survivors and carers limits the extension of findings to stroke survivors and carers of all ages in most situations. This study is not unique to all regions of Thailand. The sample represents stroke survivors and carers in Nakhon Sawan Province located in the

central part of Thailand where inhabitants are influenced by similar social norms and cultural beliefs. Moreover, this study is mainly associated with stroke survivors' and carers' personal religious belief. Because all participants are Buddhist, the findings of the study cannot readily transfer to stroke survivors and carers who believe in other religions, but rather transferring to spiritual matters in other religions. Finally, the study is based on Thai culture and Eastern philosophy. The findings based on Buddhist culture cannot be generalised in any simple way to other cultures, but there are other ways of seeing the world other than through the eyes of Western philosophy and religion- understanding the role Buddhism plays in Eastern societies. There is increasing interest and use of Buddhist approaches in the west e.g. the application of mindfulness in healthcare practice (Simpson et al. 2014; Zernicke et al. 2013). The findings can be transferable through the body of knowledge emerging from the process of attaining qualitative rigour (Ali and Yusof 2011). The generalizability of findings is inferred from general relations and patterns which give them the potential to shed light on similar situations in other contexts.

Secondly, the notion of emotion work based on Hochschild's perspective (1979) and introduced as a form of managing of emotion is at the centre of this study. The relevance of emotion work is argued through the way the individual regulates inner feelings to fit what he/she ought to feel in a particular situation regarding feeling rules framed by broad social norms and culture in the society. The main focus of the study is the nature of emotion work, taking a sociological approach to the study of emotions. This is bringing understanding through another lens. Therefore, scant attention is paid to the biological and psychological approaches.

Finally, an ethnomethodological approach (Garfinkel 1967) was applied for conducting this study. Looking into the common-sense knowledge and practical reasoning of social members in everyday living is the heart of this study, and frames the way of conceptualisation, data collection and data analysis. The detailed findings and the conceptual background to the study may raise a different perspective on emotion work in comparison with other methodologies.

10.3 Implications

This thesis elucidates the integration of components referring to the conceptual framework for the performance of emotion work among Thai stroke survivors and carers. A pragmatic goal of looking locally at the process of emotion work occurring in the family home is realised. Emotion work appears to be an ordinary but crucial activity in everyday lives to sustain interpersonal relationships in difficult circumstances. The quality of the emotion work performance is largely influenced by the feeling of gratitude and personal beliefs in the law of karma. This is an important finding for community nurses, other health professionals, policy makers, educators, researchers, and of course, stroke survivors and carers. The findings of this study indicate the need for official arrangements to support this group of people with long-term care issues and to mitigate unexpected impacts. The need for further extensive research is also necessary. A number of implications for policy, education, practice and research are discussed below.

10.3.1 Implications for policy

As a global issue, there is a lack of nursing knowledge about emotion work within family life. In Thailand, the policy emphasises a clear vision regarding well-being of Thai people and focuses on proactive health promotion and entire health-care system development. The 10th National Health Development Plan (2007-2011) aims at a "people-centred approach and the Philosophy of Sufficiency Economy" (Bureau of Policy and Strategy Ministry of Public Health 2006: 7) based on economic, social and environmental capitals including natural resources. This health policy has been implemented since the 9th plan (2002-2006). One of the strategic plans in The 10th Plan is the build-up to a new healthcare system in order to strengthen community and individuals in the Thai population, by implementing tambon (sub-district) health-promoting hospitals: THPHs (Ministry of Public Health 2012: 12). The current 11th Plan (2012-2016) follows the 10th plan vision to upgrade THPHs across the country, to enhance the ability to resolve health problems in the community, and to foster people's capabilities through health promotion and becoming self-reliant (Ministry of

Public Health 2012). In the strategic plan described above, the notion of emotion work can be integrated into the work of community nursing in order to build up stroke survivors' and carers' ability to deal effectively with their emotions in everyday living to enhance their quality of life and well-being.

As based on my findings, many strategies could be recommended to the Thai Public Health Department. According to the conceptual framework (see Figure 9.1, p. 249), the four components in the process of emotion work: context, generation, expression of emotion work and feedback, would provide valuable understanding to enable policy makers to take an overarching view with the possibility of enhancing the quality of life among people in this group. To reduce the number of inducing events for emotion work and to improve the quality of doing emotion work, policy makers should consider creating healthcare and education policies regarding emotional issues. For example, they may institute policies to foster stroke survivors' and carers' well-being lifestyle by creating a useful indicator of public concern over emotional problems; by supporting a budget to educate health providers and people in this group to understand and manage their emotions; by facilitating improvement of nursing students' learning skills regarding regulating their own emotions; by teaching the idea of emotion work in an educational course for nurses working in the community; and by allocating funds and encouraging researchers to conduct research interested in emotion work and related areas.

It can be said that emotion work remains obscure in Thai healthcare services especially in THPHs and nursing teams working in the community. The need for establishing a more holistic approach towards stroke survivors and carers in the family home and in the community is required in order to understand everyday practices that arise around the issue of emotion work. Moreover, emotion work may influence global effects of stroke survivors' and carers' quality of life and well-being. As my research shows, awareness of emotion work is vital to find the best way of dealing with the impact of emotional issues across time and place including across different groups of people (such as young and older stroke survivors and their families). With regard to public policies described earlier, it is important to draw

attention to emotion work in the areas of education, practice and research in order to cover a broader range of possible implications.

10.3.2 Implications for nursing education

The emotional labour of caring has been valued as part of the work carried out by nurses (Staden 1998; Theodosius 2008). The work of Smith (1992), who first applied emotional labour to nursing and the teaching of student nurses/student nurses' education, demonstrated the importance of emotional labour in care work. She found that 'little things' or 'gestures of caring' (Smith 1992: 1) were described by student nurses working in practice in a ward as indicators of quality of care that made a significant difference to patients' lives. The little things of caring refer to the issue of emotions and feelings (Smith 2012). The concept of emotional labour has been applied in a variety of settings and specialities such as workplace and healthcare organisations (Amble 2012; Gray and Smith 2009; Mann 2005), nurse education (Smith and Gray 2001), and research in nursing practices (Bolton 2000; Gray 2009b; Huynh et al. 2008). Research about care in the community is highly relevant to my study, which refers to the care of people with stroke at home. For example, emotion work is involved in leadership and community nursing as discussed by Haycock-Stuart et al. (2010).

Similarly to emotional labour, the concept of emotion work should also be introduced into nursing studies as an official part of training programmes in order to make preparations for training practices (for student nurses) or working (for community nurses) in a community. The concepts of emotional labour and emotion work may be taught together so that the knowledge may be applied in a practical way in working life. Understanding of the process of emotion work and the performance of emotion work among lay people in the home environment may lead to a more successful holistic approach to stroke survivors and their carers.

The findings of my study have the potential to impact on our knowledge and understanding of stroke survivors' and carers' (performance of) emotion work at

home which underlies the quality of their life and emotional well-being. The findings will also be of interest and relevance to nurses, other health professionals, social workers, stroke survivors and carers. If various forms of emotion management are valued in nurse education, it will be one way to make emotion work and emotional labour in nursing explicit in order to create a different gesture of caring and identify the skills and organisational support required to teach and apply emotional labour and emotion work in practice. The concept of emotional labour and emotion work will have the potential to influence future nursing practices in relation to working with stroke survivors and carers in the community, implications for curriculum development in both undergraduate education and continuing professional development.

10.3.3 Implications for nursing practice

The conceptual framework for the performance of emotion work among Thai stroke survivors and carers (Figure 9.1, p. 249) may be utilised directly or indirectly through continuing professional development and various training programmes. Acknowledgment of the role of emotion work, which helps stroke survivors and carers maintain their stable relationship, through training within healthcare teams would have benefits for stroke survivors and carers. A range of training should be offered to community nurses and other health professionals concerning the importance of emotion work while providing healthcare services in homes and community bases. Drawing nurses' attention to emotion work will enhance the nursing role in supporting stroke survivors and carers in dealing with their emotional difficulties. For example, nurses may be trained to recognise signs of difficulty and in how to facilitate individuals to achieve better outcomes. Nurses will be empowered to lead discussion about emotion work issues during meetings of multidisciplinary healthcare teams.

Furthermore, nurses may support stroke survivors and carers in talking about emotion work occurring in everyday life and encourage them to find out how they

can cope with the problems of an emotional misfit in a given situation. Nurses may train and teach stroke survivors and carers to successfully perform emotion work. The training and teaching may focus on self-awareness and practical skills in dealing with emotion work towards maintaining normality in the face of emotional difficulties for continuing their normal roles. This may also reduce the risk of negative impacts of undertaking emotion work on the lives of stroke survivors and carers.

The skills training for the professionals on emotion work techniques may be helpful to work with stroke survivors and carers in the community. From the findings of several research studies and my study, the act of emotion work is involved in day-to-day activities, and emotion work appears to be a useful aid to sustain a matter of routine and to face obstacles in life. For example, Minnotte et al. (2010b) reported that husbands' and wives' emotion work is significant for improving satisfaction and the quality of relationship in their marital life. Keys (2005) found that women who had experience of abortion used various emotion work techniques to encounter emotional difficulties in this particular situation. With education and training, student and community nurses would have knowledge that might ameliorate a relationship problem in family life.

The knowledge about the performance of emotion work (giving, receiving and returning) could be utilised to foster the ability to achieve emotion work. Once nurses understand the underlying significance of emotion work performance they will be enabled to help stroke survivors and carers to undertake effective emotion work. Nurses may use the sources of emotion work performance to explain the nature of engaging in emotion work to them and encourage them to become aware of emotion work in everyday living. Nurses also understand and provide basic information compatible with the needs of each person.

10.3.4 Implications for nursing research

Future research needs to be carried out on a larger sample size potentially covering a range of all regions of Thailand to receive different perspectives for representing more generalisable findings regarding emotion work in the whole country. Conducting research in the different regions in Thailand might result in different findings on the nature of emotion work among adult stroke survivors and their carers. More research is required in a range of ethnic groups and various subgroups, e.g. gender, religion, education, occupation, social class and relationship in order to identify the specific sources and the role of emotion work in other social contexts. An extension of the study could include other chronic illness patients and carers to increase understanding of emotion work in various groups of people.

According to the process of emotion work among stroke survivors and carers, it would be of benefit to examine other interpersonal relationship-related factors, e.g. other family members, relatives and social members. Those factors may impact on how individuals manage and express their feelings. Longitudinal research is also needed to further examine the relationship between the four components of the process of emotion work and to reveal different kinds of emotion work performance in different contexts in greater detail. For example, the conceptual framework could be tested and/or applied in different care contexts and/or settings.

Conducting further research into the impact of emotion work is essential for enhancing the health and well-being of stroke survivors and carers. This idea is supported by Mann's study (2005: 310) which found that there are both negative outcomes, e.g. burnout and low self-esteem, and positive outcomes, e.g. personal engagement with patients, better relationships and enhanced patient experience of healthcare providers. Similarly, there could be similar emotional consequences for the survivors and their carers. Those negative and positive outcomes might arise from undertaking emotion work among lay people. More research is important to identify different outcomes of emotion work for preventing and moderating negative outcomes and for increasing more positive outcomes.

10.4 Recommendations

This section is specifically about stroke survivors and carers. The study findings could lead to a stroke club in the community for stroke survivors and carers concerned with emotional and other issues following stroke. Club members may include stroke survivors, carers, family members of stroke survivors and other interested people. A local stroke club may run with the aim of enabling stroke survivors and carers to regain their lives and to enhance emotional well-being. The club members may take part in various activities, along with other members such as exchanging their emotional experiences with others who understand the situation, fostering relations within families, creating local social events, and helping each other to cope with emotional problems.

Drawing on a successful model of users' groups for stroke survivors and carers, (e.g. Stroke Association UK) adapted to the Thai situation, the establishment of a volunteering organisation, which aims to provide emotional support for stroke survivors and carers in Thailand, would be beneficial. A range of emotional support services may include information, advice, helpline and consultation to assist stroke survivors and carers regarding their feelings. The organisation may produce a newsletter and website to disseminate information about emotional impact and the management of emotions following stroke and news of the activities of the organisation to enhance their social life.

10.5 Conclusion

This qualitative study reveals many aspects of emotion work occurring in the family home. Data from stroke survivors' and carers' accounts of caring activities highlight their practical reasoning and methods used for managing ordinary affairs in everyday living. The results of this study clearly demonstrate the important role that emotion work plays as a routine activity in everyday life among them. Emotion work appears to be integral to individuals' personal beliefs and their social contexts. The performance of emotion work represents the act of giving and receiving the essence

of gratitude between them, and the act of returning a good thing to the other respecting their beliefs in the law of karma, unique to Buddhism/Buddhist societies.

This may be beneficial to community nurses and other health professionals to develop significant knowledge of emotion work and ability to assist stroke survivors and carers regarding their emotional welfare. Health policy makers may use the results for organising information on home-healthcare services in further stroke care and health promotion strategies in rural communities of Thailand. A benefit for stroke survivors and carers would be to have a local group or a community to share their experiences, and to obtain advice and encouragement from others. More research is required to make the importance of emotion work in normal ordinary affairs explicit. The findings regarding the use of TTR and financial problem-induced stress among stroke survivors and carers following stroke suggest a need for an orientation to holistic care and the establishment of a health service system for stroke outpatients with those issues.

The concept of emotion work is appropriate in the context of emotional support between stroke survivors and their carers in order to minimise the effects of the condition on their normal family lives. The act of emotion work appears to be commonly overlooked, perpetuating the impact on the survivors' and carers' emotional well-being. The creation of a broader knowledge base of emotion work within the home environment is a challenge. The notion of emotion work can bridge the gap between emotional aspects of care and the regulation of emotion management at home. Understanding the nature of emotion work between stroke survivors and their carers is not solely completed by drawing attention to the intrapersonal context of controlling their own feelings in everyday life. It must also concern the context of the interpersonal relationships between them, including taking into account the relation to personal beliefs and social aspects which shape their feelings and help them to maintain their role. These dimensions are linked and were found to be essential to the exchange of emotion work to fulfil the values of caring and gratitude between stroke survivors and their carers.

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Appendix 1

Interview Topic Guides

I would like to talk to you about your experiences of care involving emotions in daily life.

Interview questions for stroke survivors

1. Could you tell me about the daily routine life?
   - From your experiences in daily life such as eating, bathing, dressing and so on, how do you communicate to your carer and/ or express yourself?
   - Why do you behave like this?
   - How do you feel about this?
2. How do you cope with these feelings?
   - What do you think about the feelings and/ or emotions?
   - Why do you act in that way?
3. I would like to ask you a little about your relationship with carer.
   - How do you think (the carer's name) feels when he or she helps you?
   - Is there anything you do to help or support your carer?
   - A way of getting at how they see each other's feelings, and how they try to manage that or protect each other.
4. In your opinion, would you mind telling me about your hopes for your future health?
   - Is the carer to be a part of your everyday life or routine activities?
   - What does he or she mean for your life?
5. How is the carer most helpful to you?

Interview questions for carers

1. Tell me about how your life changed.
   - How do you feel about the change?
   - Could you describe a typical day?
2. How much responsibility do you have regarding care for stroke survivor?
   - Do you do care activities by yourself?
   - Do you have someone else helping you?
3. How difficult to care for a stroke survivor in your home?
   - Do you have any specific experiences about care activities to share with me?
4. How do you deal with feelings or emotions which occur while you are providing care?
   - What do you think about the feelings and/ or emotions?
   - Why do you act in that way?
5. In your opinion, are care activities to be a part of your everyday life or routine works?
   - How do care activities fit in your daily life?
   - Could you tell me what it means to you to be the carer?
6. How have you been maintaining your role as a main carer so far?
   - What does it mean to you to look after (the survivor's name)?

Thank you for your time and sharing your experience with me.

Today we talk about… (Summary)

Do you have anything else to say?

Do you have any questions for me?

Thank you again.

Appendix 2

Examples of Analytical Memos (Pair 2)

Pichai (husband-stroke survivor)

Critical question: "What are the practical techniques for managing emotions in everyday life between a stroke survivor and his carer and how do they develop and construct the particular aspect of emotional management?"

Memo 1 (7/11/11)

He was a fifty-year-old man who had had a stroke for 10 years ago. He lived with his wife who was the main carer and other family members: his two daughters, two granddaughters and the eldest daughter's husband. There were seven people in his family. He could walk but not very well because of a weakened right side of the body. As a researcher, I wanted to understand the nature of his everyday life in order to get his experience of emotion work between him and his wife. This was the purpose and objective of my interview.

The process of data collection consisted of three steps. I began by introducing and defining the objectives for the interview. My first goal was to build trust and make the participant understand the topics that we would discuss. At the beginning, he said that he had nothing to say. The most difficult thing was to convince the survivor to talk about his suffering. The second and third steps were taken at the same time. It was in order to confirm whether or not I totally understood him. He sometimes spoke emotionally and I misunderstood what he said. I knew what he felt because he sighed deeply and tried to speak again and again until I understood it. Therefore, I would like to know and describe his character in the next visit.

Although my plan is to conduct an interview only one time, I realised that I had to come back for a second interview. The survivor did not give me some of the information I needed to know. It might be because of his ability to answer questions

due to permanent brain damage. When I conversed with him, he took a few minutes or more to think. During the interview, I paid attention to him, his tone of voice, body language, his mood and his eyes. Reflecting through his responses, I have to be honest and acknowledge the truth of my interview. I thought that he did not have absolute trust in me, and/or I might have asked him some difficult questions. My main challenges were how to gain his trust and deciding what kind of questions would be suitable for him.

For this interview, the data I have collected so far were about his life in general, how he exercised and how much he worried about his wife when she worked outside. He talked about his feelings after he got a stroke and how he managed them. He showed me how he was dissatisfied with his wife and daughters by how he responded. His behaviour and body language expressed his feelings towards his wife. He always told me that I should talk with his wife because he could not remember completely things that happened, and his wife knew everything about him. Although I tried to ask him again and again, he gave me silence.

In the next interview, I needed to know what was his character and basic emotions before getting a stroke in order to understand his behaviour in more detail. Furthermore, I am very interested in the relationship between him and his wife. Despite always fighting, they still lived together and seemed to be happy.

Memo 2 (10/11/11)

I narrowed the focus of the second interview to concentrate on his emotions before getting a stroke. He gave me more information about the comparison between life when he was the leader of the family and life after the stroke. He told me that it was not the same anymore, and he did not like this situation. He seemed as if he accepted it, and his behaviour was changed considerably. He had become different in his behaviour because he could not behave like he used to. In the same time, he gave me some words showing that he still wanted to use violence against his wife, but he could not to do so because of his constraints. Furthermore, he talked about how much

he felt frustrated when he was forced to exercise. He did hand and arm exercises because he knew that his wife wished him well, and he had no choice.

It seemed that I could gain more trust from him because he gave me a smile and relaxed during the interview. In this visit, I took much time to explain about my work and showed him good intentions. I also used easy words to ask him questions. After finishing the second interview, there were some points that I did not explore such as his beliefs and social activities. Therefore, I intended to revisit for these points.

Memo 3 (24/12/11)

I took more than a month for revisit because of participant's wish. He needed to follow his wife into the field. In this interview, he was familiar with me. He used Ya-Moh and other treatments because of hopes. I asked him about karma which he did not believe was true. It seemed that he did not want to speak more about karma, and I needed to know why. He gave me one- minute silence and sighs deeply although I changed the question. I should get more information about karma from his wife who I would interview next. In terms of the questions about social activities, it emerged that he was rather disappointed with his friends.

In response to the critical question above, data were analysed not only from the content of his interviews, but also from field note observations. Even though the survivor did not say much, he showed a lot through his gestures, voices and other body language.

Supa (wife-carer)

Critical question: "What are the practical techniques for managing emotions in everyday life between a carer and the stroke survivor and how do they develop and construct the particular aspect of emotional management?"

Memo 1 (10/11/11)

She was forty-four years old, and she had taken care of her husband for more than ten years. She gave me an apology for missing previous interview. It was because her grandmother died. In the first interview, she provided me an amount of information, including the following.

- The background information on her life before her husband had a stroke such as occupation, income, lifestyle and relationship between her and the survivor
- How life changed after her husband had a stroke. There were both negative and positive aspects. In the negative point, she had to work hard for living and spent a lot of time and consumed more energy to take care of her husband. On the positive side, she felt happy and comfortable because she did not suffer from physical abuse anymore. I noticed that she seemed to be stressed and happy at the same time.
- She realised that she loved her husband very much, and she did not think to leave him. Although her husband occasionally treated her badly when he was drunk, he took care of her in very good ways normally. I needed to explore why she still maintained her role for many years despite having experience of the abuse.
- She told me about different emotions during the day and how she dealt with these emotions. It seemed that she had found the best way to cope after trying out many ways, but she could not explain the process. Therefore, I also concentred on this point. I knew that the answer came from many parts of interview which I had to discover.
- She strongly believed that karma was true. She gave me an example of how she believed that karma had affected her husband.

- She had no experience of taking care of a patient. When her husband had a stroke, she learned by herself to look after him. She sought the best way to made him feel happy and comfortable. She tried to treat him as a normal person.

In the second interview, I planned to interview her about what kind of treatments her husband used for curing a stroke. Because I could not get any information from the survivor about that point, I consequently would ask her on a medical matter and alternative treatments. In addition, I would focus on her emotional management.

Memo 2 (24/12/11)

She thought that using modern medicine from the hospital was to cure his hypertension and diabetes mellitus. She forced her husband to drink Ya-Moh because she heard that it could cure paralysis. The ingredients of Ya-Moh could be found in the local area, and the rest had to be bought from a shop, which sold herbal remedies. They were not too expensive. She also took her husband for injections at the same time. She said: "they weren't a doctor in the hospital, but they had medical skills and knowledge of curing this sickness. They were very famous for their own ability. I heard that there were many patients cured or at least getting better. I spent too much money with them. I didn't mind because I wanted my husband to be cured." She believed that her husband was getting better because of these treatments.

She accepted that she was very stressed, but she had to hide what she felt. It was because of love and duty. It seemed that she could tolerate difficult situations. Positive thinking could be a reason why she could maintain her emotions and her role. She tried to consider what was going on in her life, and she thought about how much better her husband had got. She then saw some neighbours who were worse than her. These were ways she used to reduce stress. Furthermore, she believed that by doing good things she would receive good things in return. She stated that she might do something wrong with her husband in a previous life that caused her to have to take care of him in return.

Appendix 3

The description of categories

Chapter 6 (stroke survivors)

1. First six months post stroke refers to experience of stroke survivors facing physical and psychological burdens in the first six months after the stroke onset.
2. Fate and karma refer to beliefs about the cause of their stroke regarding the Buddhist faith.
3. Medical reasons refer to beliefs about the cause of their stroke regarding background knowledge of stroke in a scientific way.
4. Mixing ideas refer to beliefs about the cause of their stroke regarding both the Buddhist faith and the background knowledge of a stroke.
5. Being ill refers to identifying themselves as an ill person who needs physical and psychological support from carers.
6. Being stable with physical limitations refers to identifying themselves as a person who has physical impairment but able to take care of him/herself and to continue living as usual.
7. A good carer refers to value of carers evaluated by stroke survivors, basic/ordinary support (the importance of physical and financial support from carers), and impressive/extraordinary support (the importance of mental, emotional and social support from carers).
8. Gratitude to carers refers to awareness of being grateful for carers' support.

Chapter 7 (carers)

1. A sense of duty refers to indentifying how individuals accepted the role of stroke carers.
2. Influence of ethical practices refers to value of religious beliefs and Buddhist practices in Thai people's minds.

3. Reciprocating kindness refers to value of individual moral and self-reflection in care responsibilities.
4. Stroke survivor as a disabled person refers to carers' personal judgement of placing stroke survivors' physical ability into a group of having physical limitation.
5. Stroke survivor as an ordinary person with physical limitations refers to carers' personal judgement of placing stroke survivors' physical ability into a group of getting back to a routine life.
6. Neighbouring as a source of encouragement refers to the importance of neighbours as a source of admiration, praise and information.
7. Neighbouring as a source of social pressure on carers refers to the importance of neighbours for maintaining the caring role as social pressure within a community.

Chapter 8 (stroke survivors and carers)

1. Achieving emotion work refers to managing their own emotions and feelings in order to continue their role and living as usual (surface/deep acting).
2. Acceptability refers to arriving at the acceptance of their current lives.
3. Coping strategies refer to self-protection against psychological burdens, and seeking an appropriate way to soften the impact of stroke, especially emotional issues.
4. Life experiences refer to the importance of participants' lived experience of undertaking emotion work, and emotional experience of how individuals are supposed to feel in a particular situation as accepted by social group.
5. Feeling rules refer to awareness of engaging in emotion work (the sense of gratitude and the sense of responsibility).
6. The change of gender roles refers to awareness of how gender roles changed in the family following stroke (the role of women as a primary carer in Thai culture).
7. The change of power refers to awareness of power changes in the whole family following stroke.
8. Emotion work and gender refer to the way of gender similarities and differences in undertaking emotion work.

Appendix 4

Study Information Leaflet for Stroke Survivors and Carers (Thai Language Version)

เอกสารชี้แจงการเข้าร่วมโครงการวิจัยสำหรับอาสาสมัคร

ดิฉัน นางสาวมธุรดา ม่วงมัน นักศึกษาปริญญาเอก สาขาพยาบาลศาสตร์ มหาวิทยาลัยเอดินบะระ สหราชอาณาจักร ขอเชิญท่านเข้าร่วมโครงการวิจัย และโปรดอ่านเอกสารชี้แจงเกี่ยวกับโครงการวิจัยนี้อย่างละเอียดเพื่อประกอบการตัดสินใจของท่าน ดิฉันขอขอบคุณท่านที่ตัดสินใจเข้าร่วมโครงการวิจัย หากท่านตัดสินใจไม่เข้าร่วมการวิจัยในครั้งนี้ดิฉันก็ขอขอบคุณที่ท่านสละเวลาพิจารณาและจะไม่มีผลเสียใดๆต่อท่านทั้งสิ้น กรุณาใช้เวลาในการพิจารณาตัดสินใจ และอย่าลังเลในการถามข้อสงสัยต่อดิฉันเกี่ยวกับโครงการวิจัยนี้ ดิฉันจะกลับมารับคำตอบหลังจากให้เวลาท่านตัดสินใจอย่างน้อย 24 ชั่วโมง

โครงการวิจัยนี้เป็นการศึกษาเกี่ยวกับเรื่องอะไร?

โครงการวิจัยนี้เป็นการศึกษาถึงประสบการณ์ส่วนตัวที่เกิดขึ้นในชีวิตประจำวัน ที่เกี่ยวข้องกับอารมณ์ความรู้สึกการจัดการทางอารมณ์ในระหว่างการดูแลผู้ป่วยที่บ้าน ระหว่างผู้รอดชีวิตจากโรคหลอดเลือดสมองที่อยู่ในวัยผู้ใหญ่และผู้ดูแลของพวกเขา ในเขตจังหวัดนครสวรรค์

ทำไมผู้วิจัยจึงทำโครงการวิจัยนี้?

เพราะว่าในปัจจุบันประเทศไทยยังขาดงานวิจัยที่เกี่ยวข้องกับการจัดการทางอารมณ์ระหว่างผู้รอดชีวิตจากโรคหลอดเลือดสมองที่อยู่ในวัยผู้ใหญ่และผู้ดูแล ที่สัมพันธ์กับสังคมและวัฒนธรรมไทย ประโยชน์จากการวิจัยครั้งนี้เพื่อสร้างความรู้ใหม่ และส่งเสริมการทำงานของพยาบาลและเจ้าหน้าที่ในระบบสุขภาพที่ทำงานเกี่ยวข้องกับชุมชนได้อย่างมีประสิทธิภาพ รวมทั้งยังสนับสนุนการพัฒนาคุณภาพชีวิตของผู้รอดชีวิตจากโรคหลอดเลือดสมองที่อยู่ในวัยผู้ใหญ่และผู้ดูแลอีกด้วย

อาสาสมัครต้องทำอะไรบ้างในโครงการวิจัยครั้งนี้?

ถ้าท่านเป็นอาสาสมัครในโครงการวิจัยนี้ ท่านจะต้องลงลายมือชื่อเพื่อยืนยันการตัดสินใจยินยอมเข้าร่วมโครงการวิจัย ในระหว่างการดำเนินการวิจัย ท่านจะสามารถยกเลิกการเข้าร่วมการวิจัยได้ตลอดเวลา โดยไม่มีข้อแม้ใดๆ และไม่ต้องบอกเหตุผลการยกเลิกใดๆ ทั้งสิ้น

ในระหว่างการดำเนินการวิจัย ดิฉันจะพูดคุยกับท่านเกี่ยวกับประสบการณ์ด้านอารมณ์ความรู้สึกที่เกิดขึ้นขณะการทำกิจกรรมการดูแลผู้ป่วยที่บ้านในชีวิตประจำวัน ซึ่งจะเป็นการพูดคุยกันแบบตัวต่อตัว และใช้เวลาประมาณ 45-60 นาที นอกจากนี้ท่านจะสามารถเลือกเวลาและสถานที่ในการพูดคุยสนทนาได้ ตามสะดวก ดิฉันจะขออนุญาตท่านแต่ละคนเพื่อบันทึกเสียงการพูดคุย นอกจากนี้ยังมีการสังเกตการทำกิจกรรมการดูแลผู้ป่วยอีกด้วย โดยสรุปแล้วดิฉันจะเข้ามาพบท่านอย่างน้อย 3 ครั้ง ครั้งแรกเพื่ออธิบายรายละเอียดเกี่ยวกับโครงการวิจัย ตอบคำถามของท่าน และให้เวลาท่านอย่างน้อย 24 ชั่วโมงเพื่อตัดสินใจว่าจะเข้าร่วมโครงการนี้หรือไม่ ครั้งที่สองเพื่อการพูดคุยกันทั้งผู้รอดชีวิตจากโรคหลอดเลือดสมองและผู้ดูแล ซึ่งการพูดคุยนี้อาจจะแบ่ง

ออกเป็นสองครั้งตามความสะดวกของท่านเอง และในการพบครั้งสุดท้ายเพื่อจะนำบทสรุปของการพูดคุยมาให้ท่านแต่ละคนพิจารณาว่าถูกต้อง และครบถ้วนหรือไม่ และเป็นอย่างไร

โครงการวิจัยนี้จะมีอันตรายต่ออาสาสมัครหรือไม่?

ในระหว่างการพูดคุย ท่านอาจจะรู้สึกอึดอัด หรือไม่สบายใจได้ ถ้าเหตุการณ์ดังกล่าวเกิดขึ้น ดิฉันจะหยุดการพูดคุยและหยุดอัดเสียงทันที ท่านสามารถตัดสินใจได้ว่าจะพูดคุยต่อหรือจะยกเลิกก็ได้ นอกจากนี้ในระหว่างหรือหลังจากการพูดคุยแล้ว ถ้าท่านไม่สบายใจหรือถ้าท่านต้องการพูดคุยกับพยาบาลชุมชนที่ดูแลครอบครัวของท่าน (ที่ดิฉันติดต่อไว้ก่อนที่จะมาพบท่านในวันนี้) ดิฉันสามารถส่งต่อและรายงานไปยังเจ้าหน้าที่ดังกล่าวได้ ทั้งนี้ต้องได้รับการอนุญาตจากท่านก่อน

โครงการวิจัยนี้จะมีผลประโยชน์ต่ออาสาสมัครหรือไม่?

ท่านจะไม่ได้รับค่าตอบแทนใดๆจากการเข้าร่วมโครงการวิจัยในครั้งนี้ อย่างไรก็ตามผลการวิจัยจะเป็นประโยชน์ในการพัฒนาประสิทธิภาพของระบบบริการสุขภาพในชุมชนต่อไป

ข้อมูลส่วนตัวของอาสาสมัครจะถูกเก็บเป็นความลับหรือไม่?

ข้อมูลทุกอย่างของท่านจะเก็บไว้ในตู้ล็อกและเก็บเป็นความลับไว้ในสถานที่ที่ปลอดภัยเป็นระยะเวลา 10 ปี หลังจากที่ท่านลงลายมือชื่อในใบยินยอมเข้าร่วมโครงการวิจัย หลังจากนั้นข้อมูลทั้งหมดจะถูกลบทิ้งทันที มีแต่ดิฉันและอาจารย์ผู้ควบคุมดูแลการวิจัยครั้งนี้เท่านั้นที่จะสามารถดูข้อมูลเหล่านี้ได้ หลังเสร็จสิ้นการศึกษาข้อมูลจะถูกตีพิมพ์และนำเสนอในภาพรวม โดยจะไม่มีการอ้างชื่อ ที่อยู่ หรือสิ่งใดๆ ที่จะสามารถสืบค้นไปถึงท่านได้

จะมีอะไรเกิดขึ้นกับผลการศึกษาหรือไม่?

ผลการวิจัยจะถูกตีพิมพ์เป็นวิทยานิพนธ์ระดับปริญญาเอก และเก็บไว้ที่ห้องสมุดของมหาวิทยาลัยเอดินบะระ นอกจากนี้ดิฉันยังต้องรายงานไปยังกระทรวงสาธารณสุข ประเทศไทย เนื่องจากเป็นแหล่งทุนของการวิจัยครั้งนี้ อีกทั้งผลการวิจัยจะถูกไปตีพิมพ์ในวารสารวิชาการ และจะเผยแพร่ไปสู่ประชาชนทั่วไปที่สนใจทางจดหมายข่าว เอกสารอิเลคโทรนิกส์ และอินเตอร์เนตต่อไป

จะทำอย่างไรถ้าอาสาสมัครมีข้อสงสัย?

ท่านสามารถติดต่อดิฉันได้ตลอดเวลาถ้าหากมีข้อซักถามเกี่ยวกับโครงการวิจัยนี้ ทางโทรศัพท์ 081-281-1559 หรือส่งจดหมายมายังที่อยู่ดังนี้ วิทยาลัยพยาบาลบรมราชชนนี สวรรค์ประชารักษ์นครสวรรค์ 45 ถ.อรรถกวี อ.เมือง จ.นครสวรรค์ 60000 หรือทางอีเมล์ s1019939@sms.ed.ac.uk

โครงการวิจัยนี้อยู่ในการควบคุมดูแลของศาสตราจารย์แพม สมิท และด็อกเตอร์แมรีออน สมิท คุณสามารถแน่ใจได้ว่าการศึกษาครั้งนี้ได้มีการป้องกันความเสียหายหรืออันตรายที่อาจเกิดขึ้นกับท่าน ซึ่งโครงร่างวิจัย ผ่านความเห็นชอบจากคณะกรรมการจริยธรรมการวิจัยในคนของคณะพยาบาลศาสตร์ มหาวิทยาลัยเอดินบะระ และโรงพยาบาลสวรรค์ประชารักษ์ และขออนุญาตเก็บรวบรวมข้อมูลอย่างเป็นทางการจาก สำนักงานสาธารณสุขจังหวัด จังหวัดนครสวรรค์แล้ว

ขอขอบคุณท่านสำหรับการสละเวลาอ่านเอกสารฉบับนี้ และดิฉันหวังว่าท่านจะตัดสินใจเข้าร่วมโครงการ

Appendix 5

Study Information Leaflet for Stroke Survivors and Carers (English Language Version)

Participant Information Sheet

I am Miss Maturada Muangman, a PhD research student in the School of Health in Social Science at The University of Edinburgh, Scotland, United Kingdom. This is an invitation to take part in a research project. Please read carefully this information sheet which contains a brief summary of the study and its aim before you decide whether to participate. I thank you if you decide to take part. If you decide not to participate I also thank you for your consideration and there is no disadvantage of any kind to you. Please take time to consider this invitation and do not hesitate to contact me if you have any questions or want additional information about this study. I would be grateful to receive your decision following a 24 hour consideration period.

What is this study about?

This project will explore personal experience of emotion management during care activities at home in everyday life among adult stroke survivors and their carers in rural areas of Nakhon Sawan Province, Thailand.

Why am I doing this study?

At present, there is a lack of Thai research into stroke and related disabilities in the community, and little is known about the nature of emotional management between stroke survivors and their carers in relation to Thai culture. This study aims to help nurses and health providers to gain new knowledge and enhance intervention in home-healthcare activities for providing effective support in order to promote adult stroke survivors' and their carers' quality of life.

What do participants do in this study?

If you volunteer to participate, you will be asked to sign a consent form. During the project, your participation remains voluntary and you can withdraw at any time. You will not be asked to give a reason for withdrawing.

In this study, I will ask you some questions about the experience of care involving emotions in daily life which will take the form of a series of one to one interview(s) lasting 45-60 minutes. The time and location for interviews will be set up at each participant's convenience.

I would like to record our conversation with your permission. These recordings will be used only for research purposes. With your permission I will also observe participants during care activities so that I can understand what is involved in daily care of stroke survivors. Thus, I would like to visit you a minimum of 3 times, first to explain my study, answer your questions, and seek your permission to

continue; secondly to interview both carer and stroke sufferer-this may mean two visits if that is more convenient for you; and thirdly to present a summary of your interview transcripts for your approval.

What are the possible risks of taking part?

You may feel uncomfortable or distressed during our conversation. If these situations happen, I will stop the interview and the recorder will be switched off. You can decide whether or not to continue. During or following interviews, if you would like to talk to someone else, I will be in contact with a psychiatric specialist or a community nurse and a transfer system will be set up before the study has started for protecting you against psychological harm.

What are any benefits of taking part?

You will not be given any payment or incentives to be involved in this study. However, the results of this study will be useful for improving effective health care services.

Will data be kept confidential?

Any information both digital audio recordings and transcriptions will remain strictly confidential and kept in a locked cabinet. Only I and my supervisors will have access to your personal details. No identifying materials about you will be given in the report, and you will remain anonymous. The raw data will be retained in a secure zone for ten years after each participant has signed an authorisation and then will be destroyed.

What will happen to the study results?

The findings will be published as a doctoral thesis and will be kept in the University of Edinburgh Library. The results of this study will also be reported to the Thai Royal Government who has funded this study. In addition, the findings will be published in academic and professional journals. I will publish for lay audiences e.g. newsletters and websites for encouraging the voluntary and care community and other interested people to learn from this study.

What should participants do if they have any questions?

You may directly contact me for asking any questions or for more details about this study, either now or in the future through telephone 081-2811-559 or post to Boromarajonani College of Nursing Sawanpracharak Nakhon Sawan 45 Attakawee Rd., Muang Nakhon Sawan, Thailand 60000 or e-mail S1019939@sms.ed.ac.uk

This project is being supervised by Professor Pam Smith and Dr. Marion Smith. The participants are ensured that they are protected from harm. The proposal is approved by the Ethics Committee, the School of Health in Social Science, the University of Edinburgh and the Ethical Committee of Sawanpracharak hospital and by the Director of the Nakhon Sawan Provincial Public Health Department, Thailand.

Thank you for reading this and I hope you will decide to participate.

Appendix 6

Informed Consent Form (Thai Language Version)

หนังสือยินยอมเข้าร่วมโครงการวิจัย

ชื่อเรื่อง: การดำเนินชีวิตภายหลังเกิดโรคหลอดเลือดสมอง: การทำงานทางอารมณ์ของผู้รอดชีวิตจากโรคหลอดเลือดสมองวัยผู้ใหญ่ และผู้ดูแล ในพื้นที่ชนบทจังหวัดนครสวรรค์

ข้าพเจ้า (นางสาว /นาง /นาย)..... ยินยอมที่จะเข้าร่วมโครงการวิจัย ที่นางสาวมธุรดา ม่วงมัน (นักศึกษาปริญญาเอก) กำลังดำเนินการศึกษาเกี่ยวกับประสบการณ์ชีวิตที่สัมพันธ์กับอารมณ์ความรู้สึก ของผู้รอดชีวิตจากโรคหลอดเลือดสมองที่อยู่ในวัยผู้ใหญ่และผู้ดูแลของพวกเขาที่เกิดขึ้นในชีวิตประจำวันระหว่างกิจกรรมการดูแลผู้ป่วยที่บ้าน

ข้าพเจ้าเข้าใจว่าข้อมูลจะถูกเก็บรวบรวมโดยการสัมภาษณ์และการสังเกต ซึ่งการสัมภาษณ์จะใช้เวลาประมาณ 45-60 นาที นอกจากนี้ข้าพเจ้าจะสามารถเลือกเวลาและสถานที่ตามที่ข้าพเจ้าสะดวกในการสัมภาษณ์ได้

ข้าพเจ้าเข้าใจและยินยอมที่จะบันทึกเสียงการสัมภาษณ์ ซึ่งในการบันทึกเสียงนี้ใช้สำหรับการวิจัยครั้งนี้เท่านั้น และข้าพเจ้าเข้าใจว่าข้อมูลส่วนตัวของข้าพเจ้าจะถูกเก็บเป็นความลับไว้ในสถานที่ที่ปลอดภัยเป็นเวลา 10 ปี หลังจากที่ข้าพเจ้าลงลายมือชื่อในใบยินยอมเข้าร่วมโครงการวิจัย หลังจากนั้นข้อมูลทั้งหมดจะถูกลบทิ้งทันที ข้าพเจ้ายังเข้าใจอีกว่าหลังจากเสร็จสิ้นการศึกษาครั้งนี้ การนำเสนอข้อมูลจะถูกตีพิมพ์โดยภาพรวม และจะไม่มีการอ้างชื่อ ที่อยู่ หรือสิ่งใดๆ ที่จะสามารถสืบค้นไปยังข้าพเจ้าได้

ข้าพเจ้ารู้และเข้าใจว่าข้าพเจ้าและครอบครัวจะไม่ได้รับค่าตอบแทนใดๆ จากการเข้าร่วมโครงการวิจัยในครั้งนี้ อย่างไรก็ตามผลการวิจัยจะสามารถส่งเสริม พัฒนา และเพิ่มประสิทธิภาพด้านการดูแลสุขภาพผู้ป่วย และผู้ดูแลในชุมชนได้ และข้าพเจ้าเข้าใจว่าการตัดสินใจเข้าร่วมโครงการวิจัยในครั้งนี้ เป็นทางเลือกของข้าพเจ้า และความเสี่ยงส่วนบุคคลมีโอกาสเกิดขึ้นได้น้อย ข้าพเจ้ายังเข้าใจอีกว่าข้าพเจ้าสามารถถอนตัวออกจากการวิจัยครั้งนี้ได้ตลอดเวลาโดยไม่จำเป็นต้องให้เหตุผลใดๆ และจะไม่เกิดผลเสียใดๆ ต่อข้าพเจ้าทั้งสิ้น

ข้าพเจ้าได้อ่านข้อมูล หรือมีผู้อ่านข้อมูลนี้ให้แก่ข้าพเจ้า นอกจากนี้ข้าพเจ้าได้รับโอกาสที่จะถามคำถาม และได้รับคำตอบทั้งหมดจนกระทั่งข้าพเจ้าพึงพอใจ และข้าพเจ้าได้รับเอกสารข้อมูลเกี่ยวกับการวิจัยครั้งนี้ เพื่อประกอบการพิจารณา ข้าพเจ้ายังสามารถถามคำถามเกี่ยวกับการวิจัยต่อผู้วิจัยทางโทรศัพท์ได้ตลอดเวลา

ข้าพเจ้าลงลายมือชื่อ เพื่อเป็นหลักฐานการตัดสินใจเข้าร่วมโครงการวิจัยครั้งนี้ และในกรณีที่อาสาสมัครไม่สามารถอ่านหรือเขียนได้ ให้พิมพ์นิ้วหัวแม่มือไว้เป็นหลักฐาน

อาสาสมัคร: ผู้วิจัย: วัน/เดือน/ปี:

Appendix 7

Informed Consent Form (English Language Version)

The University of Edinburgh
School of Health in Social Science
Informed Consent Form

Study title: Life after Stroke: Emotion Work among Adult Stroke Survivors and Carers in the Rural Areas of Nakhon Sawan Province, Thailand

I,……(print name) hereby agree to take part in the study that Maturada Muangman (PhD student) is conducting about life experiences during care activities at home in relation to emotions in daily life among adult stroke survivors and their carers.

I understand that the data will be gathered through interviews and observations. The interviewing period is for about 45-60 minutes, and I can choose the location and a time at my convenience.

I understand and agree that the interview will be recorded. The recording will be used only for research proposes and the data will be destroyed after I have signed an authorization for ten years. I also understand that my personal information will be stored in a secure area and will be confidential until it is destroyed with the data. I understand that findings will be published after completion of the study but that all participants will be anonymous and personal identifying material will not be published.

I know that there will not be any direct benefits for me and my family. However, the results of this study will be useful for improving effective health care services. Furthermore, I know that participation in this study is my choice and the personal risks are minimal. I understand that I can withdraw from this study at any time without giving any reason and there will not be any disadvantage to me.

I have read the information, or it has been read to me. I have been given the chance to ask questions and all such questions about the study have been answered to my satisfaction. I received a participant information sheet for ensuring I totally understand the study. I may ask any further questions about the study and contact the researcher at any time via the researcher's phone number or e-mail address provided.

If you are not able to read or write

Participants who are cannot read or write should include their thumb print as well.

Participant: Researcher: Date: